Nevada Medicaid

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

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

June 18, 2018

Medicaid Management Information System (MMIS)
Department of Health and Human Services (DHHS)
Division of Health Care Financing and Policy (DHCFP)
Disclosure Statement

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

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

About DHCFP

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

Table of Contents

1 Introduction .................................................................................................................. 4
   1.1 NCPDP Batch Transaction Standard Version 1.2 and Telecommunication Standard Version D.0 .................................................................................. 4

2 Getting Started ........................................................................................................... 5
   2.1 Trading Partner Registration .................................................................................. 5
   2.2 Certification and Testing Overview ....................................................................... 6

3 Testing with Nevada Medicaid .................................................................................... 7
   3.1 Testing Process ..................................................................................................... 7
   3.2 File Naming Standard ......................................................................................... 7
   3.3 Duplicate Pharmacy Logic ................................................................................... 8

4 Connectivity with Nevada Medicaid/ Communications ............................................... 10
   4.1 Process Flows ...................................................................................................... 10
   4.2 Encounter Response Files .................................................................................... 11
   4.3 Transmission Administrative Procedures ............................................................. 11
   4.4 System Availability ............................................................................................. 11
   4.5 Transmission File Size ....................................................................................... 12
   4.6 Re-transmission Procedure .................................................................................. 12
   4.7 Communication Protocol Specifications .............................................................. 12
   4.8 Passwords ............................................................................................................ 12
   4.9 NCPDP Batch Transaction Standard Version 1.2 .................................................. 12
   4.10 Separator Characters ......................................................................................... 13

5 NCPDP Batch Transaction Standard Version 1.2 File Information and Telecommunication Standard Version D.0 Transaction Set Specifications ...................................................... 14
   5.1 Transmission Header (Required/1 per file) ............................................................ 14

6 NCPDP Version 1.2 .................................................................................................... 16
   6.1 Transaction Detail (Required/1 per transaction) ..................................................... 16
   6.2 NCPDP D.0 Billing Request (Required) ................................................................. 16
   6.3 Insurance Segment (Required) ............................................................................. 17
   6.4 Patient Segment (Situational) .............................................................................. 17
   6.5 Claim Segment (Required) ................................................................................... 18
   6.6 Pricing Segment (Required) ................................................................................ 20
   6.7 Provider Segment (Required) .............................................................................. 21
   6.8 Prescriber Segment (Required) ............................................................................ 21
   6.9 COB/Other Payments Segment (Situational) ...................................................... 21
6.10 DUR/PPS Segment (Situational) ................................................................. 22
6.11 Compound Segment (Situational) ............................................................. 22
6.12 Clinical Segment (Required for Encounter) .................................................. 23
6.13 Transmission Trailer (1 per file required) .................................................... 23

7 The NCPDP Encounter Response File .............................................................. 25
7.1 File layout of the NCPDP Encounter Response File ....................................... 25

8 Encounter Claim Duplicate File ....................................................................... 26

9 Contact Information .......................................................................................... 27
9.1 EDI Customer Service .................................................................................... 27
9.2 EDI Technical Assistance ............................................................................... 27
9.3 Applicable Websites/Email ........................................................................... 28

Appendix A: Dispense as Written (DAW) Product Selection Code ....................... 30
Appendix B: Other Coverage Code ....................................................................... 32
Appendix C: Other Payer Amount Paid Qualifier .................................................. 33
Appendix D: Reason for Service Code .................................................................. 34
Appendix E: Professional Service Code ............................................................... 38
Appendix F: Result of Service Code ...................................................................... 40
Appendix G: Compound Dosage Form Description Code ....................................... 42
Appendix H: Compound Ingredient Bases of Cost Determination ......................... 43
Appendix I: Frequently Asked Questions ............................................................. 44
1 Introduction

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

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

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

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

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

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

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

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

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

2.1 Trading Partner Registration

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

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

- A Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Nevada Medicaid requires all Trading Partners to complete a TPP agreement regardless of the Trading Partner type listed below.

- Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
  - Software vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
  - Billing service is a third party that prepares and/or submits claims for a provider.
  - Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

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

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

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

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

This section provides a general overview of what to expect during certification and testing phases. All Trading Partners who submit electronic transactions with Nevada Medicaid will be certified through the completion of Trading Partner testing. This includes Clearinghouses, Software Vendors, Provider Groups and Managed Care Organizations (MCOs).

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

This section contains a detailed description of the testing phase.

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

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

The following Encounter transactions are available for testing:

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

3.1 Testing Process

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

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

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

3.2 File Naming Standard

Use the following naming standards when submitting encounter files to Nevada Medicaid.
3.3 Duplicate Pharmacy Logic

Pharmacy Logic

Logic will consider each Detail on the incoming claim.
Logic will consider history claims.

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

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

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

Considering the ‘dispense date’ as the Date of first service.

Check current pharm detail against history claim details.

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

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

Then set ENC DUP PHARM

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

- If a claim is denied at the Header level, it does not get added to the audit history table.
- If a Paid claim at the Header level has details that were denied, those denied details do not get added to the history table
- Thus, only paid details will be found on the audit history table for comparison
4 Connectivity with Nevada Medicaid/Communications

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

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

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

4.1 Process Flows

This section contains a process flow diagram and appropriate text.
4.2 Encounter Response Files

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

2. EDI processes the batch.
   
   Note: With an NCPDP transaction, the TA1 and 999 responses are not available. If an error is detected with a batch/file, the Trading Partner will be contacted via email from the EDI Helpdesk. The email will contain the reason why the file rejected.

3. When the batch successfully processes through EDI, the encounter claims are transformed into XML records and submitted to the interChange Encounter Claim engine for further validation and processing. At this stage, individual encounter claims are inspected and if necessary rejected and sent back to the submitter for correction. (When resubmitting a rejected encounter claim, the same MCO ICN/TCN must be used on the corrected encounter claim). The submitter can expect two different response files as follows:
   
   - The proprietary encounter NCPDP response report will be generated daily once the translated file has processed. This report will contain the status of each encounter claim within the transaction. The Encounter Engine contains informational and threshold edits. Both types of edits are reported on the response file; however, only threshold edits will reject a claim. A claim with no edits or informational edits will be accepted. Claims can have both threshold and informational edits, but only the information pertaining to the threshold edit will need to be corrected and resubmitted for the claim to be accepted. If a claim within the batch is rejected due to duplicate, then an Encounter Claim Duplicate file will also be generated. This file provides information on the current claim that is being rejected and the related claim in the Encounter Claim Engine.

4.3 Transmission Administrative Procedures

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

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

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

4.4 System Availability

The system is typically available 24X7 with the exception of scheduled maintenance windows as noted on the Nevada Medicaid Provider Web Portal at [https://www.medicaid.nv.gov/](https://www.medicaid.nv.gov/).
4.5 Transmission File Size

<table>
<thead>
<tr>
<th>Transactions</th>
<th>Submission Method</th>
<th>File Size Limit</th>
<th>Other Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCPDP</td>
<td>SFTP</td>
<td>200 MB per batch</td>
<td></td>
</tr>
<tr>
<td>NCPDP</td>
<td>Web Portal</td>
<td>4 MB</td>
<td></td>
</tr>
</tbody>
</table>

4.6 Re-transmission Procedure

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

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

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

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

4.7 Communication Protocol Specifications

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

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


4.8 Passwords

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

4.9 NCPDP Batch Transaction Standard Version 1.2

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

06/18/2018
- Header (1 per file)
- Transaction Detail (can include 1 transaction)
- Trailer (1 per file)

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

4.10 Separator Characters

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

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

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

Each field has a unique identifier code that, when used in conjunction with the Field Separator, shows the start of a new field in the record (for example, FB refers to Field 511-FB, Reject Code).
5 NCPDP Batch Transaction Standard Version 1.2 File Information and Telecommunication Standard Version D.0 Transaction Set Specifications

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

The following definitions are given to ensure consistency of interpretation:

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

### 5.1 Transmission Header (Required/1 per file)

<table>
<thead>
<tr>
<th>Field</th>
<th>Use</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>880-K4</td>
<td>M</td>
<td>Text Indicator</td>
<td>A/N</td>
<td>1</td>
<td>Start of Text (STX) = X’02’</td>
</tr>
<tr>
<td>701</td>
<td>M</td>
<td>Segment Identifier</td>
<td>A/N</td>
<td>2</td>
<td>00 = File Control Header</td>
</tr>
<tr>
<td>880-K6</td>
<td>M</td>
<td>Transmission Type</td>
<td>A/N</td>
<td>1</td>
<td>T = Transaction</td>
</tr>
<tr>
<td>880-K1</td>
<td>M</td>
<td>Sender ID</td>
<td>A/N</td>
<td>24</td>
<td>Trading Partner ID assigned by Nevada Medicaid.</td>
</tr>
<tr>
<td>806-5C</td>
<td>M</td>
<td>Batch Number</td>
<td>N</td>
<td>7</td>
<td>Assigned by the sender and must match the Transaction Trailer Batch Number field.</td>
</tr>
<tr>
<td>880-K2</td>
<td>M</td>
<td>Creation Date</td>
<td>N</td>
<td>8</td>
<td>Create Date = CCYYMMDD</td>
</tr>
<tr>
<td>880-K3</td>
<td>M</td>
<td>Creation Time</td>
<td>N</td>
<td>4</td>
<td>Create Time = HHMM</td>
</tr>
<tr>
<td>702</td>
<td>M</td>
<td>File Type</td>
<td>A/N</td>
<td>1</td>
<td>P = Production</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>T = Test</td>
</tr>
<tr>
<td>Field</td>
<td>Use</td>
<td>Field Name</td>
<td>Format</td>
<td>Length</td>
<td>Values/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>---------------------</td>
<td>--------</td>
<td>--------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>102-A2</td>
<td>M</td>
<td>Version/Release Number</td>
<td>A/N</td>
<td>2</td>
<td>12 = Version 1.2</td>
</tr>
<tr>
<td>880-K7</td>
<td>M</td>
<td>Receiver ID</td>
<td>A/N</td>
<td>24</td>
<td>NVMED</td>
</tr>
<tr>
<td>880-K4</td>
<td>M</td>
<td>Text Indicator</td>
<td>A/N</td>
<td>1</td>
<td>End of Text (ETX) = X’03’</td>
</tr>
</tbody>
</table>
# 6 NCPDP Version 1.2

## 6.1 Transaction Detail (Required/1 per transaction)

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

## 6.2 NCPDP D.0 Billing Request (Required)

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>101-A1</td>
<td>BIN Number</td>
<td>N</td>
<td>6</td>
<td>Use “9999999”</td>
</tr>
<tr>
<td>102-A2</td>
<td>Version/Release Number</td>
<td>A/N</td>
<td>2</td>
<td>D0 = Version D.0</td>
</tr>
<tr>
<td>103-A3</td>
<td>Transaction Code</td>
<td>A/N</td>
<td>2</td>
<td>B1 = Billing</td>
</tr>
</tbody>
</table>
| 104-A4 | Processor Control Number    | A/N    | 10     | Audit Number assigned at point of adjudication.                                 
Number assigned by processor. Suggestion: Populate unique characters in the first nine bytes to prevent processing number duplication.  
MCO Internal Control Number |
| 109-A9 | Transaction Count           | X      | 1      | 1 = One occurrence                                                               |
| 202-B2 | Service Provider ID Qualifer| A/N    | 2      | 01 = NPI/API                                                                     
05 = Medicaid                                                      
Note: 05 is only valid for “Atypical” Providers - all other providers must submit their NPI (Value = 01), File will be rejected if value other than 01 or 05 is submitted. |
| 201-B1 | Service Provider ID         | A/N    | 15     | Billing Provider NPI                                                             
Note: In the current NV Medicaid Encounter System, this value is sent in field 444-E9, |
6.3 Insurance Segment (Required)

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

6.4 Patient Segment (Situational)

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>Segment Identification</td>
<td>N</td>
<td>2</td>
<td>01= Patient</td>
</tr>
<tr>
<td>304-C4</td>
<td>Date of Birth</td>
<td>N</td>
<td>8</td>
<td>Format: CCYYMMDD</td>
</tr>
</tbody>
</table>
### 6.5 Claim Segment (Required)

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>Segment Identification</td>
<td>N</td>
<td>2</td>
<td>07 = Claim</td>
</tr>
<tr>
<td>455-EM</td>
<td>Prescription/ Service Reference Number Qualifier</td>
<td>N</td>
<td>1</td>
<td>1 = Rx Billing</td>
</tr>
<tr>
<td></td>
<td>Notes: “1” is the only value accepted. All other values will reject the file.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>402-D2</td>
<td>Prescription/ Service Reference Number</td>
<td>N</td>
<td>12</td>
<td>Prescription Number</td>
</tr>
<tr>
<td></td>
<td>Note: When prescription number is less than the required length, leading zeroes are not required, may use spaces to make max length but this is not required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>436-E1</td>
<td>Product/Service ID Qualifier</td>
<td>A/N</td>
<td>2</td>
<td>03 = NDC</td>
</tr>
<tr>
<td>Field</td>
<td>Field Name</td>
<td>Format</td>
<td>Length</td>
<td>Values/Comments</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>407-D7</td>
<td>Product/Service ID</td>
<td>A/N</td>
<td>11</td>
<td>NDC  [MMMMMNNNNP] (M = ) NDC Mfg Code (N = ) NDC Nbr (P = ) NDC Pkg Code</td>
</tr>
<tr>
<td>457-EP</td>
<td>Associated Prescription/ Service Date</td>
<td>A/N</td>
<td>8</td>
<td>Date Format CCYYMMDD</td>
</tr>
<tr>
<td>442-E7</td>
<td>Quantity Dispensed</td>
<td>9(7)v999</td>
<td>10</td>
<td>10 Digit Metric decimal quantity of drug dispensed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Format = 999999999.999</td>
</tr>
<tr>
<td>403-D3</td>
<td>Fill Number</td>
<td>A/N</td>
<td>2</td>
<td>00 - New (original dispensing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01 to 99 = Refill Number</td>
</tr>
<tr>
<td>405-D5</td>
<td>Days’ Supply</td>
<td>N</td>
<td>3</td>
<td>Estimated number of days the prescription will last.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: When days’ supplied are less than the required length, leading zeroes are not</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>required, may use spaces to make max length but this is not required.</td>
</tr>
<tr>
<td>406-D6</td>
<td>Compound Code</td>
<td>N</td>
<td>1</td>
<td>1 = Not a Compound  (2 = ) Compound</td>
</tr>
<tr>
<td>408-D8</td>
<td>Dispense As Written (DAW)/Product</td>
<td>N</td>
<td>1</td>
<td>See Appendix A</td>
</tr>
<tr>
<td></td>
<td>Selection Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>414-DE</td>
<td>Date Prescription Written</td>
<td>N</td>
<td>8</td>
<td>Date Format CCYYMMDD</td>
</tr>
<tr>
<td>419-DJ</td>
<td>Prescription Origin Code</td>
<td>N</td>
<td>1</td>
<td>0 = Not Known  (1 = ) Written  (2 = ) Telephone  (3 = ) Electronic  (4 = ) Facsimile  (5 = ) Pharmacy</td>
</tr>
<tr>
<td>308-C8</td>
<td>Other Coverage Code</td>
<td>N</td>
<td>2</td>
<td>See Appendix B</td>
</tr>
<tr>
<td>461-EU</td>
<td>Prior Authorization Type Code</td>
<td>N</td>
<td>2</td>
<td>Must be submitted when 462-EV is present.</td>
</tr>
</tbody>
</table>
### 6.6 Pricing Segment (Required)

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

Note: In the current NV Medicaid Encounter System, this value is sent in field 490-UE, **COMPOUND INGREDIENT BASIS OF COST DETERMINATION**
### 6.7 Provider Segment (Required)

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

### 6.8 Prescriber Segment (Required)

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>Segment Identification</td>
<td>N</td>
<td>2</td>
<td>03 = Prescriber</td>
</tr>
<tr>
<td>466-EZ</td>
<td>Prescriber ID Qualifier</td>
<td>N</td>
<td>2</td>
<td>01 = NPI</td>
</tr>
<tr>
<td>411-DB</td>
<td>Prescriber ID</td>
<td>A/N</td>
<td>15</td>
<td>Prescriber NPI ID</td>
</tr>
</tbody>
</table>

### 6.9 COB/Other Payments Segment (Situational)

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

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

### 6.11 Compound Segment (Situational)

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>111-AM</td>
<td>Segment Identification</td>
<td>N</td>
<td>2</td>
<td>10 = Compound</td>
</tr>
<tr>
<td>450-EF</td>
<td>Compound Dosage Form Description Code</td>
<td>A/N</td>
<td>2</td>
<td>See Appendix G</td>
</tr>
<tr>
<td>451-EG</td>
<td>Compound Dispensing Unit Form Indicator</td>
<td>N</td>
<td>1</td>
<td>1 = Each</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 = Grams</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 = Milliliters</td>
</tr>
<tr>
<td>447-EC</td>
<td>Compound Ingredient Component Count</td>
<td>N</td>
<td>2</td>
<td>Count of compound product IDs (both active and inactive) in the compound mixture submitted.</td>
</tr>
<tr>
<td>488-RE</td>
<td>Compound Product ID Qualifier</td>
<td>A/N</td>
<td>2</td>
<td>03 = NDC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99 = Other (Container Count) Must be accompanied with all 9’s and a 7 (999999999) in field 489-TE. When a product ID of all 9’s and a 7 (9999999999) is submitted then the quantity in field 448-ED will be considered the Container Count. Repeating field depending on count found in</td>
</tr>
<tr>
<td>Field</td>
<td>Field Name</td>
<td>Format</td>
<td>Length</td>
<td>Values/Comments</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>489-TE</td>
<td>Compound Product ID</td>
<td>A/N</td>
<td>19</td>
<td>National Drug Code (NDC)</td>
</tr>
<tr>
<td>448-ED</td>
<td>Compound Ingredient Quantity</td>
<td>9(7)v999</td>
<td>10</td>
<td>Compound Ingredient Quantity. Amount expressed in metric decimal units of the product included in the compound mixture. Implied decimal, no overpunch required</td>
</tr>
<tr>
<td>490-UE</td>
<td>Compound Ingredient Basis of Cost Determination</td>
<td>A/N</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

### 6.12 Clinical Segment (Required for Encounter)

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

### 6.13 Transmission Trailer (1 per file required)

<table>
<thead>
<tr>
<th>Field</th>
<th>Use</th>
<th>Field Name</th>
<th>Format</th>
<th>Length</th>
<th>Values/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>880-K4</td>
<td>M</td>
<td>Text Indicator</td>
<td>A/N</td>
<td>1</td>
<td>Start of Text (STX) = X’02’</td>
</tr>
<tr>
<td>701</td>
<td>M</td>
<td>Segment Identifier</td>
<td>A/N</td>
<td>2</td>
<td>99 = File Trailer Record</td>
</tr>
<tr>
<td>806-5C</td>
<td>M</td>
<td>Batch Number</td>
<td>N</td>
<td>7</td>
<td>Assigned by the sender and must match the Transaction Header Batch Number field.</td>
</tr>
<tr>
<td>751</td>
<td>M</td>
<td>Record Count</td>
<td>N</td>
<td>10</td>
<td>Count of detail records, including header and trailer. A transaction detail can contain up to four transactions. The transaction detail would be counted only once.</td>
</tr>
<tr>
<td>Field</td>
<td>Use</td>
<td>Field Name</td>
<td>Format</td>
<td>Length</td>
<td>Values/Comments</td>
</tr>
<tr>
<td>---------</td>
<td>-----</td>
<td>-----------------</td>
<td>--------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>504-F4</td>
<td>M</td>
<td>Message</td>
<td>A/N</td>
<td>35</td>
<td>The message field can be used to further explain the reasons why the entire batch is in error or any other information that needs to be sent regarding the batch. This field should only contain informational data and should not contain required data.</td>
</tr>
<tr>
<td>880-K4</td>
<td>M</td>
<td>Text Indicator</td>
<td>A/N</td>
<td>1</td>
<td>End of Text (ETX) = X’03’</td>
</tr>
</tbody>
</table>
7 The NCPDP Encounter Response File

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

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

7.1 File layout of the NCPDP Encounter Response File

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

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

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

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

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

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

9.1 EDI Customer Service

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

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

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

9.2 EDI Technical Assistance

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

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

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

For written correspondence:

Nevada Medicaid

PO Box 30042

Reno, Nevada 89520-3042
9.3 Applicable Websites/Email

This section contains detailed information about useful websites.


- Accredited Standards Committee (ASC X12N): ASC X12N develops and maintains X12 EDI and XML standards, standards interpretations, and guidelines as they relate to all aspects of insurance and insurance-related business processes. [www.x12.org](http://www.x12.org).

- American Dental Association (ADA): Develops and maintains a standardized data set for use by dental organizations to transmit claims and encounter information. [www.ada.org](http://www.ada.org).

- American Hospital Association Central Office on ICD-10-CM/ICD-10-PCS (AHA): This site is a resource for the International Classifications of Diseases, 10th edition, Clinical Modification (ICD-10-CM) codes, used for reporting patient diagnoses and (ICD-10-PCS) for reporting hospital inpatient procedures. [www.ahacentraloffice.org](http://www.ahacentraloffice.org).


- Committee on Operating Rules for Information Exchange (CORE): A multi-phase initiative of Council for Affordable Quality Healthcare, CORE is a committee of more than 100 industry leaders who help create and promulgate a set of voluntary business rules focused on improving physician and hospital access to electronic patient insurance information at or before the time of care. [www.caqh.org/CORE_overview.php](http://www.caqh.org/CORE_overview.php).

- Council for Affordable Quality Healthcare (CAQH): A nonprofit alliance of health plans and trade associations, working to simplify healthcare administration through industry collaboration on public-private initiatives. Through two initiatives – the Committee on Operating Rules for Information Exchange and Universal Provider Datasource – CAQH aims to reduce administrative burden for providers and health plans. [www.caqh.org](http://www.caqh.org).

- Designated Standard Maintenance Organizations (DSMO): This site is a resource for information about the standard-setting organizations and transaction change request system: [www.hipaa-dsмо.org](http://www.hipaa-dsмо.org).

- Health Level Seven (HL7): HL7 is one of several ANSI-accredited Standards Development Organizations (SDOs), and is responsible for clinical and administrative data standards. [www.hl7.org](http://www.hl7.org).

• National Committee on Vital and Health Statistics (NCVHS): The National Committee on Vital and Health Statistics was established by Congress to serve as an advisory body to the Department of Health and Human Services on health data, statistics and national health information policy. www.ncvhs.hhs.gov.

• National Council of Prescription Drug Programs (NCPDP): The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org.

• National Uniform Billing Committee (NUBC): NUBC is affiliated with the American Hospital Association. It develops and maintains a national uniform billing instrument for use by the institutional health-care community to transmit claims and encounter information. www.nubc.org.

• National Uniform Claim Committee (NUCC): NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org.

• Nevada Department of Health and Human Services (DHHS) Division of Health Care Financing and Policy (DHCFP): The DHCFP website assists policy questions: http://dhcfp.nv.gov and this website assists providers with billing and enrollment support. www.medicaid.nv.gov.

• Office for Civil Rights (OCR): OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa.


• Workgroup for Electronic Data Interchange (WEDI): WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org.
Appendix A: Dispense as Written (DAW) Product Selection Code

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code indicating whether or not the prescriber’s instructions regarding generic substitution were followed.</td>
<td>x(1)</td>
</tr>
</tbody>
</table>

Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Product Selection Indicated - This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.</td>
</tr>
<tr>
<td>1</td>
<td>Substitution Not Allowed by Prescriber - This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.</td>
</tr>
<tr>
<td>2</td>
<td>Substitution Allowed - Patient Requested Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</td>
</tr>
<tr>
<td>3</td>
<td>Substitution Allowed - Pharmacist Selected Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.</td>
</tr>
<tr>
<td>4</td>
<td>Substitution Allowed - Generic Drug Not in Stock - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.</td>
</tr>
<tr>
<td>5</td>
<td>Substitution Allowed - Brand Drug Dispensed as a Generic - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the Pharmacist is utilizing the brand product as the generic entity.</td>
</tr>
<tr>
<td>6</td>
<td>Override - This value is used by various claims processors in very specific instances as defined by that claims processor and/or its client(s).</td>
</tr>
</tbody>
</table>
| 7    | Substitution Not Allowed - Brand Drug Mandated by Law - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>brand product even though generic versions of the product may be available in the marketplace.</td>
</tr>
<tr>
<td>8</td>
<td>Substitution Allowed - Generic Drug Not available in Marketplace - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed or is temporarily unavailable.</td>
</tr>
<tr>
<td>9</td>
<td>Other - This value is reserved and currently not in use. NCPDP does not recommend use of this value at the present time. Please contact NCPDP if you intend to use this value and document how it will be utilized by your organization.</td>
</tr>
</tbody>
</table>
## Appendix B: Other Coverage Code

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code indicating whether or not the patient has other insurance coverage.</td>
<td>9(2)</td>
</tr>
</tbody>
</table>

### Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Specified</td>
</tr>
<tr>
<td>1</td>
<td>No other coverage identified</td>
</tr>
<tr>
<td>2</td>
<td>Other coverage exists, payment collected</td>
</tr>
<tr>
<td>3</td>
<td>Other coverage exists, this claim not covered</td>
</tr>
<tr>
<td>4</td>
<td>Other coverage exists, payment not collected</td>
</tr>
<tr>
<td>8</td>
<td>Claim is a billing for a copay</td>
</tr>
</tbody>
</table>
# Appendix C: Other Payer Amount Paid Qualifier

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code qualifying the 'Other Payer Amount Paid' (431-DV).</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

## Values:

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

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code identifying the type of utilization</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR</td>
<td>Adverse Drug Reaction – Code indicating an adverse reaction by a patient to a drug.</td>
</tr>
<tr>
<td>AT</td>
<td>Additive Toxicity – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself.</td>
</tr>
<tr>
<td>CD</td>
<td>Chronic Disease Management – The patient is participating in a coordinated health care intervention program.</td>
</tr>
<tr>
<td>CH</td>
<td>Call Helpdesk – Processor message to recommend the receiver contact the processor/plan.</td>
</tr>
<tr>
<td>CS</td>
<td>Patient Complaint/Symptom – Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.</td>
</tr>
<tr>
<td>DA</td>
<td>Drug-Allergy – Indicates that an adverse immune event may occur due to the patient’s previously demonstrated heightened allergic response to the drug product in question.</td>
</tr>
<tr>
<td>DC</td>
<td>Drug-Disease (Inferred) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient’s medication history.</td>
</tr>
<tr>
<td>DD</td>
<td>Drug-Drug Interaction – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately.</td>
</tr>
<tr>
<td>DF</td>
<td>Drug-Food interaction – Indicates interactions between a drug and certain foods.</td>
</tr>
<tr>
<td>DI</td>
<td>Drug Incompatibility – Indicates physical and chemical incompatibilities between two or more drugs.</td>
</tr>
<tr>
<td>DL</td>
<td>Drug-Lab Conflict – Indicates that laboratory values may be altered due to the use of the drug, or that the patient’s response to the drug may be altered due to a condition that is identified by a certain laboratory value.</td>
</tr>
<tr>
<td>DM</td>
<td>Apparent Drug Misuse – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber.</td>
</tr>
<tr>
<td>DR</td>
<td>Dose Range Conflict – Code indicating that the prescription does not follow recommended medication dosage.</td>
</tr>
<tr>
<td>DS</td>
<td>Tobacco Use – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>ED</td>
<td>Patient Education/Instruction – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber’s instructions on the prescription.</td>
</tr>
<tr>
<td>ER</td>
<td>Overuse – Code indicating that the current prescription refill is occurring before the days’ supply of the previous filling should have been exhausted.</td>
</tr>
<tr>
<td>EX</td>
<td>Excessive Quantity – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed.</td>
</tr>
<tr>
<td>HD</td>
<td>High Dose – Detects drug doses that fall above the standard dosing range.</td>
</tr>
<tr>
<td>IC</td>
<td>Iatrogenic Condition – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected.</td>
</tr>
<tr>
<td>ID</td>
<td>Ingredient Duplication – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected.</td>
</tr>
<tr>
<td>LD</td>
<td>Low Dose – Code indicating that the submitted drug doses fall below the standard dosing range.</td>
</tr>
<tr>
<td>LK</td>
<td>Lock In Recipient – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type; hence the member is “locked in” to using only those providers or pharmacies.</td>
</tr>
<tr>
<td>LR</td>
<td>Underuse – Code indicating that a prescription refill that occurred after the days’ supply of the previous filling should have been exhausted.</td>
</tr>
<tr>
<td>MC</td>
<td>Drug-Disease (Reported) – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist.</td>
</tr>
<tr>
<td>MN</td>
<td>Insufficient Duration – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product’s common uses, has been detected.</td>
</tr>
<tr>
<td>MS</td>
<td>Missing Information/Clarification – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information.</td>
</tr>
<tr>
<td>MX</td>
<td>Excessive Duration – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product’s common uses.</td>
</tr>
<tr>
<td>NA</td>
<td>Drug Not Available – Indicates the drug is not currently available from any source.</td>
</tr>
<tr>
<td>NC</td>
<td>Non-covered Drug Purchase – Code indicating a cognitive service whereby a patient is counseled, the pharmacist’s recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug.</td>
</tr>
<tr>
<td>ND</td>
<td>New Disease/Diagnosis – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>NF</td>
<td>Non-Formulary Drug – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient’s pharmacy benefit plan.</td>
</tr>
<tr>
<td>NN</td>
<td>Unnecessary Drug – Code indicating that the drug is no longer needed by the patient.</td>
</tr>
<tr>
<td>NP</td>
<td>New Patient Processing – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient.</td>
</tr>
<tr>
<td>NR</td>
<td>Lactation/Nursing Interaction – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant.</td>
</tr>
<tr>
<td>NS</td>
<td>Insufficient Quantity – Code indicating that the quantity of dosage units prescribed is insufficient.</td>
</tr>
<tr>
<td>OH</td>
<td>Alcohol Conflict – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages.</td>
</tr>
<tr>
<td>PA</td>
<td>Drug-Age – Indicates age-dependent drug problems.</td>
</tr>
<tr>
<td>PC</td>
<td>Patient Question/Concern – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care.</td>
</tr>
<tr>
<td>PG</td>
<td>Drug-Pregnancy – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus.</td>
</tr>
<tr>
<td>PH</td>
<td>Preventive Health Care – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.</td>
</tr>
<tr>
<td>PN</td>
<td>Prescriber Consultation – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient.</td>
</tr>
<tr>
<td>PP</td>
<td>Plan Protocol – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient’s plan and submits a claim for the professional service provided.</td>
</tr>
<tr>
<td>PR</td>
<td>Prior Adverse Reaction – Code identifying the patient has had a previous atypical reaction to drugs.</td>
</tr>
<tr>
<td>PS</td>
<td>Product Selection Opportunity – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists.</td>
</tr>
<tr>
<td>RE</td>
<td>Suspected Environmental Risk – Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors.</td>
</tr>
<tr>
<td>RF</td>
<td>Health Provider Referral – Patient referred to the pharmacist by another health care provider for disease specific or general purposes.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>SC</td>
<td>Suboptimal Compliance – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of noncompliance.</td>
</tr>
<tr>
<td>SD</td>
<td>Suboptimal Drug/Indication – Code indicating incorrect, inappropriate or less than optimal drug prescribed for the patient’s condition.</td>
</tr>
<tr>
<td>SE</td>
<td>Side Effect – Code reporting possible major side effects of the prescribed drug.</td>
</tr>
<tr>
<td>SF</td>
<td>Suboptimal Dosage Form – Code indicating incorrect, inappropriate or less than optimal dosage form for the drug.</td>
</tr>
<tr>
<td>SR</td>
<td>Suboptimal Regimen – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question.</td>
</tr>
<tr>
<td>SX</td>
<td>Drug-Gender – Indicates the therapy is inappropriate or contraindicated in either males or females.</td>
</tr>
<tr>
<td>TD</td>
<td>Therapeutic – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected.</td>
</tr>
<tr>
<td>TN</td>
<td>Laboratory Test Needed – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy.</td>
</tr>
<tr>
<td>TP</td>
<td>Payer/Processor Question – Code indicating that a payer or processor requested information related to the care of a patient.</td>
</tr>
<tr>
<td>UD</td>
<td>Duplicate Drug – Code indicating that multiple prescriptions of the same drug formulation are present in the patient’s current medication profile.</td>
</tr>
</tbody>
</table>
### Appendix E: Professional Service Code

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

**Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No intervention</td>
</tr>
<tr>
<td>AS</td>
<td>Patient assessment – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan.</td>
</tr>
<tr>
<td>CC</td>
<td>Coordination of care – Case management activities of a pharmacist related to the care being delivered by multiple providers.</td>
</tr>
<tr>
<td>DE</td>
<td>Dosing evaluation/determination – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication’s dose, interval, frequency and/or formulation.</td>
</tr>
<tr>
<td>DP</td>
<td>Dosage evaluated – Code indicating that dosage has been evaluated with respect to risk for the patient.</td>
</tr>
<tr>
<td>FE</td>
<td>Formulary enforcement – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange.</td>
</tr>
<tr>
<td>GP</td>
<td>Generic product selection – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer.</td>
</tr>
<tr>
<td>M0</td>
<td>Prescriber consulted – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem.</td>
</tr>
<tr>
<td>MA</td>
<td>Medication administration – Code indicating an action of supplying a medication to a patient through any of several routes — oral, topical, intravenous, intramuscular, intranasal, etc.</td>
</tr>
<tr>
<td>MB</td>
<td>Overriding benefit – Benefits of the prescribed medication outweigh the risks.</td>
</tr>
<tr>
<td>MP</td>
<td>Patient will be monitored – Prescriber is aware of the risk and will be monitoring the patient.</td>
</tr>
<tr>
<td>MR</td>
<td>Medication review – Code indicating comprehensive review and evaluation of a patient’s entire medication regimen.</td>
</tr>
<tr>
<td>PA</td>
<td>Previous patient tolerance – Patient has taken medication previously without issue.</td>
</tr>
<tr>
<td>PE</td>
<td>Patient education/instruction – Code indicating verbal and/or written communication by a pharmacist to enhance the patient’s knowledge about the condition under treatment or to develop skills and competencies related to its management.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>PH</td>
<td>Patient medication history – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile.</td>
</tr>
<tr>
<td>PM</td>
<td>Patient monitoring – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered.</td>
</tr>
<tr>
<td>P0</td>
<td>Patient consulted – Code indicating patient communication related to collection of information or clarification of a specific limited problem.</td>
</tr>
<tr>
<td>PT</td>
<td>Perform laboratory test – Code indicating that the pharmacist performed a clinical laboratory test on a patient.</td>
</tr>
<tr>
<td>RO</td>
<td>Pharmacist consulted other source – Code indicating communication related to collection of information or clarification of a specific limited problem.</td>
</tr>
<tr>
<td>RT</td>
<td>Recommend laboratory test – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient.</td>
</tr>
<tr>
<td>SC</td>
<td>Self-care consultation – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment.</td>
</tr>
<tr>
<td>SW</td>
<td>Literature search/review – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.</td>
</tr>
<tr>
<td>TC</td>
<td>Payer/processor consulted – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient.</td>
</tr>
<tr>
<td>TH</td>
<td>Therapeutic product interchange – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer.</td>
</tr>
<tr>
<td>ZZ</td>
<td>Other Acknowledgement. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.</td>
</tr>
</tbody>
</table>
### Appendix F: Result of Service Code

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

#### Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Not specified</td>
</tr>
<tr>
<td>1A</td>
<td>Filled as is, false positive</td>
</tr>
<tr>
<td>1B</td>
<td>Filled prescription as is</td>
</tr>
<tr>
<td>1C</td>
<td>Filled with different dose</td>
</tr>
<tr>
<td>1D</td>
<td>Filled with different directions</td>
</tr>
<tr>
<td>1E</td>
<td>Filled with different drug</td>
</tr>
<tr>
<td>1F</td>
<td>Filled with different quantity</td>
</tr>
<tr>
<td>1G</td>
<td>Filled with prescription approval</td>
</tr>
<tr>
<td>1H</td>
<td>Brand – To – generic change</td>
</tr>
<tr>
<td>1J</td>
<td>RY – to – OTC change</td>
</tr>
<tr>
<td>1K</td>
<td>Filled with different dosage form</td>
</tr>
<tr>
<td>2A</td>
<td>Prescription not filled</td>
</tr>
<tr>
<td>2B</td>
<td>Not filled, directions clarified</td>
</tr>
<tr>
<td>3A</td>
<td>Recommendation accepted</td>
</tr>
<tr>
<td>3B</td>
<td>Recommendation not accepted</td>
</tr>
<tr>
<td>3C</td>
<td>Discontinued drug</td>
</tr>
<tr>
<td>3D</td>
<td>Regimen changed</td>
</tr>
<tr>
<td>3E</td>
<td>Therapy changed</td>
</tr>
<tr>
<td>3F</td>
<td>Therapy changed – cost increased acknowledged</td>
</tr>
<tr>
<td>3G</td>
<td>Drug therapy unchanged</td>
</tr>
<tr>
<td>3H</td>
<td>Follow-up/report</td>
</tr>
<tr>
<td>3I</td>
<td>Patient referral</td>
</tr>
<tr>
<td>3K</td>
<td>Instructions understood</td>
</tr>
<tr>
<td>3M</td>
<td>Compliance aid provided</td>
</tr>
<tr>
<td>3N</td>
<td>Medication Administered</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>4N</td>
<td>Prescribed with acknowledgments</td>
</tr>
</tbody>
</table>
**Appendix G: Compound Dosage Form Description Code**

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dosage form of the complete compound mixture.</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

**Values:**

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

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.</td>
<td>x(2)</td>
</tr>
</tbody>
</table>

Values:

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

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

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

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

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

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

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

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

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

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

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

Q: What transaction type should a corrected encounter record be submitted as (PAID, REPLACEMENT)? B1 OR B3?
A: We only allow B1 transactions. Encounters doesn’t currently have replacement or resubmission processing. Adjustments can be sent and the instructions are in Companion Guide.

Q: Are there any requirements to submit separate files based on membership, plan, etc.?
A: No.

Q: Is there any requirement noted that certain transactions cannot go on the same file (i.e. PAID, VOID/REVERSAL, and/or correction records on separate files)?
A: No.

Q: Will response files be generated for full file rejections?
A: All files are currently full rejections.

Q: Can multiple NCPDP encounter files be submitted in a single day?
A: You can submit multiple files per day and per week.

Q: Will the response file be sent with line-feed or single string of data?
A: It is a file with end of record.

Q: Is a response returned for each record? Would an NCPDP Encounter claim be suspended for later processing?
A: Yes, and it’s at the level of the batch. It’ll list multiple edits, whether informational or threshold. The response record, once accepted, will receive an Encounter ICN. The word ‘rejected’ denotes reject.

Q: When can we expect the response file to be returned after the NCPDP file is submitted?
A: You will see it first thing the following morning.

Q: If we submit multiple files in a day, how are the response files returned?
A: One response file per submission file will be returned.