NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE

UNINSURED CARE PROGRAMS
AIDS DRUG ASSISTANCE PROGRAM (ADAP)
PHARMACY PROVIDER MANUAL

Uninsured Care Programs
Empire Station
P.O. Box 2052
Albany, NY 12220-0052
1-800-542-2437
1-844-682-4058

NEW YORK STATE OF OPPORTUNITY. | Department of Health

PHARMACY PROVIDER MANUAL
UNINSURED CARE PROGRAMS
AIDS DRUG ASSISTANCE PROGRAM (ADAP)

BACKGROUND

The AIDS Institute has established programs for uninsured or underinsured New York residents living with or at risk of acquiring HIV/AIDS. The AIDS Drug Assistance Program (ADAP) provides life-saving medications; ADAP Plus provides HIV primary care services; the Home Care Program provides care in the home; the ADAP Plus Insurance Continuation (APIC) program provides assistance in paying health insurance premiums to support access to comprehensive health care coverage in a cost-effective manner; the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) provides access to primary care services and monitoring to support the use of Pre-Exposure Prophylaxis (PrEP) to prevent HIV infection. These programs are centrally administered, use a unified application form and coordinate outreach activities.

AIDS DRUG ASSISTANCE PROGRAM (ADAP) DESCRIPTION

ADAP provides reimbursement for medications (specific formulary) for New York State residents who meet program eligibility criteria. The ADAP formulary may change as new drugs are approved by the FDA and available resources allow. Any program change which decreases covered medications will be sent in writing to participants and providers. The most current ADAP Formulary can be found at the Department of Health website:
http://www.health.ny.gov/diseases/aids/resources/adap/formulary.htm

The enrollment and claims processing functions of this program are integrated with that of ADAP Plus and Home Care for improved coordination and efficiency.

FUTURE DIRECTIONS

The Program's Clinical Advisory Workgroup is continually investigating current and new medications to provide access to medications useful to all participants, while using scarce resources to the fullest extent possible. Requests for formulary additions or changes should be addressed in writing to the Director at:

UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052

POPULATION SERVED

ADAP serves persons living with HIV who are uninsured or underinsured New York residents living with HIV/AIDS who meet established eligibility criteria. Applicants who have partial insurance or limitations on their insurance may be eligible. Applicants who are enrolled in Medicaid and approved for ADAP with a Medicaid Spenddown or Surplus are only eligible when Medicaid is not active. Participants who are enrolled in a Medicare Part D plan are eligible, with ADAP as the secondary payer. (see section Medicare Part D)

Information on applying for the Uninsured Care Programs can be found under “Health Insurance Programs” on the Department of Health website: **http://www.health.ny.gov**

Applicants who meet program eligibility criteria receive a program eligibility card. Participants are required to present their eligibility card at a participating pharmacy along with a prescription to receive the approved medication(s). There is **NO co-payment** requirement for ADAP participants.

PARTICIPANT ELIGIBILITY

1) Residency - Must be living in New York State.

2) Medical - Must be living with HIV (or HIV negative for PrEP-AP and Hep-CAP).

3) Financial - Financial eligibility is based on 500% of the Federal Poverty Level (FPL). FPL varies based on household size and is updated annually.

PARTICIPANT ENROLLMENT PROCESS

- Applicants apply to the Programs, providing proof of residency, income, and insurance (if applicable).
- A Medical Application completed by a physician is required, verifying HIV-infection and indicating medical/disease status.
- Upon determination of eligibility, a program eligibility card is sent to the applicant that may be used to receive prescriptions from an enrolled pharmacy provider for covered medications. If a participant has no insurance or insurance that provides insufficient coverage the participant will be issued a standard eligibility card.

IDENTIFICATION OF PARTICIPANT ELIGIBILITY

ADAP eligibility is not retroactive. Medications dispensed before ADAP approval will not be reimbursed. The Programs assign a unique identification number to every participant at the time of enrollment. Each participant is issued a program eligibility card listing their unique 11-character identification number and the date of eligibility. Participants enrolled in ADAP must present their current eligibility card whenever they have a prescription filled at an ADAP enrolled pharmacy.

The unique identification number on the program eligibility card is presented in this format: 555999999ØA. The “Cardholder ID” field (3Ø2-C2) is an 11-digit field. Cards printed prior to November 2016 will contain dashes in the ID number field. To avoid transaction rejections, enter all digits when submitting claims, omitting the dashes: 555999999ØA.

Pharmacies must submit all claims electronically, using NCPDP version D.0 including the COB segment of the transaction if appropriate. Utilization of the Point of Sale system will verify the participant’s eligibility and specific drug coverage as well as process and adjudicate claims. There is no formal testing process for D.0, however, providers may call and request that ADAP monitor the initial transmission of D.0 transactions.

MEDICARE PART D

Participants who are eligible for Medicare Part D must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). If a participant requires medication and presents an Uninsured Care Programs ID Card, you **must** also ask for a Medicare Prescription Drug Plan Card. The Programs will coordinate benefits with Medicare Prescription Drug Plans (PDP). **ADAP is secondary payer to Medicare Part D plans except in cases when the participant has a Medicaid Spenddown and is <u>not</u> Medicaid active** (See below, *Medicare Part D* and *Medicaid Spenddown*).

MEDICAID

Medicaid covers the cost of prescription drugs; therefore, individuals enrolled in Medicaid are not eligible for ADAP. However, individuals awaiting Medicaid eligibility determination, or who have Medicaid Spenddown requirements **are** eligible. ADAP assistance may be provided on a short-term basis to persons eligible for, or pending Medicaid approval. Once other coverage becomes available, the participant will no longer receive ADAP coverage for prescription drugs. The Programs reserve the right to deny any claims for individuals who have active Medicaid eligibility covering prescription drugs and interface with Medicaid to prevent duplication of enrollment and billing. Providers are required to identify and encourage potential Medicaid eligible participants to enroll in Medicaid.

MEDICAID SPENDDOWN ELIGIBILITY VERIFICATION

The Uninsured Care Programs have a directive from the New York State Department of Health that requires the Programs to assist individuals who have a Medicaid Spenddown to meet their spenddown amounts (91-ADM-11 NYS DSS). To respond to this directive and to expedite the process, the following procedures have been established:

a) ADAP participants who have an income Spenddown will receive a program eligibility card that has the words **"MEDICAID SPENDDOWN"** printed on the card.

b) If a participant requires medication and presents a program eligibility card identified as Medicaid Spenddown, you **must** first try to use their **Medicaid card or Medicaid Identification #** to determine that they are **not** eligible under Medicaid to receive the medication.

c) If a participant is not eligible for Medicaid, ADAP can be used to provide the medication and seek reimbursement as usual from ADAP. You **must** verify eligibility through the ADAP Point of Sale system. **IN THIS INSTANCE ONLY**, you will issue a standard receipt or statement of expenditures incurred to the participant in the amount of the ADAP billing. The participant is responsible for bringing the receipt to their local Medicaid office to have that amount applied to their Spenddown requirements. If the system denies the prescription, **and** the participants Medicaid is not active, call the Programs' hotline at **1-800-542-2437 or 1-844-682-4058**.

d) The first time a Medicaid Spenddown/ADAP participant uses this process, they must provide you with a copy of the letter issued to them by the Programs describing their Spenddown amounts and the process for meeting it. If they cannot provide a copy of this letter, please contact program eligibility staff at **1-800-542-2437 or 1-844-682-4058** for clarification and approval.

MEDICARE PART D & MEDICAID SPENDDOWN

One of the goals of the Ryan White HIV/AIDS Treatment Extension Act of 2009 is to provide access to comprehensive health care for people living with HIV and AIDS. To accomplish this goal for individuals who are Medicare active and have a Medicaid Spenddown, the Programs will institute a Medicaid Spenddown verification letter. The letter is sent to participants who need to meet their Medicaid Spenddown which states the amount of the Medicaid Spenddown to be met. Billing ADAP as primary payer in these instances allows ADAP to meet the participant's Medicaid Spenddown and ensure comprehensive health care coverage for the participant.

The Programs will only pay for the medication or medications required to meet the amount of the Medicaid Spenddown. Claims submitted for medications exceeding the Medicaid Spenddown will be denied with the denial code 41 stating "Submit Bill to Other Processor or Primary Payer."

Example – John Jones, an ADAP participant with Medicare Part D coverage and a Medicaid Spenddown arrives at the pharmacy with his Medicaid Spenddown verification letter stating his Spenddown is $240. Mr. Jones needs to fill prescriptions for pain medication and heart medication. Refilling either prescription would exceed the $240-dollar Spenddown; therefore, after the first medication is submitted and approved for full payment by ADAP, the second medication will need to be billed through the participant's Medicare Part D Plan.

PHARMACY PROVIDER ELIGIBILITY & ENROLLMENT

All licensed New York State pharmacies are eligible to enroll as ADAP providers if actively enrolled in the New York State Elderly Pharmaceutical Insurance Coverage (EPIC) program, enrolled with one or more Medicare Prescription Drug Plans, and are actively enrolled or have begun the enrollment process with New York State Medicaid. Newly enrolled ADAP pharmacy providers will be allowed to submit claims to the Programs for up to **90 days** while their Medicaid application is being processed. Pharmacy providers who do not maintain active EPIC, New York State Medicaid, and one or more Medicare Prescription Drug Plan enrollment will be terminated as an ADAP pharmacy provider.

Eligible pharmacies must complete an initial Pharmacy Enrollment Agreement Form from the Programs as part of the ADAP enrollment process. To assure the integrity of enrolled pharmacy providers, ADAP requires updated agreement forms on a periodic basis. ADAP utilizes the Pharmacies' EPIC enrollment status and NABP (National Association of Board Pharmacies) identification number or NPI (National Provider Identification) number to verify pharmacy eligibility. Pharmacies must recertify with EPIC and ADAP periodically to maintain payment eligibility.

The pharmacy must inform the Programs in writing of any changes to their pharmacy information. Should the pharmacy experience a change of ownership, the pharmacy must notify New York State Medicaid, EPIC **and** ADAP immediately of the change and re-enrollment of the pharmacy in all programs is required. The pharmacy is responsible for ensuring that the change of provider information with EPIC and ADAP is seamless and without coverage gaps. Failure to re-enroll in EPIC will result in non-payment of ADAP claims billed by the pharmacy while the EPIC enrollment is inactive. Failure to re-enroll in Medicaid will result in the termination of the pharmacy as an ADAP provider.

Pharmacies outside New York State must be enrolled with NYS Medicaid, maintain a valid pharmacy license in their appropriate state, and submit claims electronically, utilizing current NCPDP D.0 standards and an NABP identification number or NPI number. Pharmacies outside of New York State must request to participate as an enrolled provider with ADAP in writing; complete a pharmacy enrollment agreement form; and provide documentation of NYS Medicaid enrollment, Medicare Prescription Drug Plan participation and current pharmacy license.

Mail Order Specialty Pharmacies outside New York State are eligible to enroll as ADAP pharmacy providers. At this time, enrollment of mail order specialty pharmacies in New York State Medicaid and/or EPIC is requested but not required by the Programs. Enrollment of mail order specialty pharmacies allows the Programs to provide **secondary coverage only** for mail order prescriptions approved by a participants' primary insurance. Coordination of benefits with the primary payer is required (see section *Coordination of Benefits*). Prescriptions may be filled for a 90-day supply only if the primary insurance company mandates the use of a mail order specialty pharmacy and a 90-day fill.

ADAP DISPENSING AND BILLING PROCEDURES

340B DISCOUNT PROGRAM

Pharmacies eligible to purchase drugs under Public Health Service (PHS) Section 340B may not use 340B stock for New York ADAP participants.

REIMBURSEMENT

ADAP adheres to New York State Medicaid reimbursement methodology when administratively feasible for all medications covered by the Programs. In the case of generics versus brand name medications where an Orange Book rated equivalent is available; no dispense as written override is available unless the medication is specifically precluded from a mandatory generic category by NYS Medicaid.

If the drug dispensed is a multiple source prescription drug for which a specific federal upper limit has been established, the Programs make payment based on the federal upper limit. If the drug dispensed is a federal source prescription drug or a brand-name prescription drug for which no specific federal upper limit has been set, payment will be made based on the package size dispensed as reported by the prescription drug pricing service used by ADAP; AWP less 17.0 percent for brand name medications and AWP less 25.0 percent for generics and over-the-counter (OTC) agents covered by ADAP. ADAP's prescription drug pricing service is currently "Medispan." Drug prices are updated weekly. ADAP does not make retroactive adjusting payments for drug price changes occurring during the week.

Dispensing Fees:	Generic - Multiple source	$3.50
	Brand products	$3.50
	Vitamins & Nutritional Supplements	$3.50

To ensure timely reimbursement, submit claims promptly. All reimbursement is issued by Health Research, Inc. (HRI), and accompanied by a remittance statement detailing payments and denials. When inquiring about a claim submission or payment amount, have the **authorization number** or **batch number** and the detailed explanation of payment available for discussion.

CLAIM SUBMISSION

The Processor Control Number (PCN) used for billing claims to ADAP is **ADAPØ1** unless coordinating benefits on a Medicare Part D claim. (See section "*Coordination of Benefits*" below) Providers must be certified to submit claims electronically to the Elderly Pharmaceutical Insurance Coverage (EPIC) program to be certified as an ADAP Provider. Contact your claim submission software vendor when you first enroll with ADAP. The software vendor will require the following information:

ANSI BIN Number: **610490** / State: **New York** / ADAP Destination: **Albany, N.Y.**

Participating pharmacies are required to submit ADAP claims on-line using industry standard Point of Sale (POS) procedures. Up to four claims may be submitted within a single transaction. All POS transactions for ADAP are routed through the following commercial switching companies: Relay Health and Emdeon Business Services. ADAP accepts POS claims for processing between the hours of 7:00 AM and 10:00 PM seven days a week. The initial fill of a prescription (Refill 00) must occur within 60 days of the prescription date. All billing transactions must be submitted within 14 days of dispensing medication. Claims are processed for payment on a weekly basis. Generally, reimbursement will be made to pharmacies within 21 days of electronic claim submission. Automated Clearing House (ACH) payments are available to pharmacies who are receive electronic delivery of their 835 remittance statements. Pharmacies can contact the Provider

Relations Section at **1-800-832-5305** for information regarding ACH and electronic 835 enrollment options.

To deter fraud and abuse, pharmacists must ask to see the Uninsured Care Programs eligibility card for all ADAP participants each time they present for a prescription. You must ask the participant for any other insurance card(s) they may have.

Prescriptions should be filled for a one month supply. Current program limitations preclude prescriptions for longer than a 30-day period unless a prior approval is processed. In cases where serious hardships would result for the participant, please contact ADAP at **1-800-542-2437 or 1-844-682-4058**. ADAP limits prescription refills to five. **Automatic refills are NOT allowed**; the participant must contact the pharmacy for each refill. Partial prescription claim submission is supported by NCPDP D.0 in the event the pharmacy does not have adequate supply on hand.

Questions regarding our Point of Sale system, please contact the Director, Computer Systems.

From within New York State: **1-800-542-2437 or 1-844-682-4058**
From outside New York State: **518-459-1641**

COORDINATION OF BENEFITS

Pharmacies are required to submit the participant's prescriptions to the primary insurance carrier every time a prescription is filled. ADAP must be billed as secondary/tertiary where there is other coverage.

Medicare Part D – TrOOP & COB: ADAP must be billed as a secondary payer for individuals who have active Part D coverage. This means that Other Coverage Code (308-C8) must contain values of 2, 3, 4, or 8. Claims that do not indicate that ADAP is being billed after the primary (based on the value of 308-C8) will be denied with a code of 41 ('Submit bill other processor or primary payer'). ADAP has established a Processor Control Number (PCN) that must be used for all claim transactions where the participant has active Part D coverage. In these cases, the PCN is "**TROOPUCP**". Using the incorrect PCN will result in a claim denial with the error codes M1 ('Patient not covered in this aid category') and 04 ("Invalid PCN Number"). It is necessary to use the correct PCN so that TrOOP can be calculated accurately in real time.

CLAIM REVERSALS

ADAP Pharmacy Providers can reverse a claim electronically (NCPDP B2 transaction) within 30 days of the date of service. Electronic reversals of a claim that is part of a pharmacy batch which has been processed and closed will result in an off-cycle claim adjustment against the current open pharmacy batch; whereby the total amount of all off-cycle adjustments will be deducted from the payment due to the pharmacy. The adjustment code XO (off-cycle claim reversal) will appear on the remittance statement in the comments section. If you receive an 835 file, the value of field CLP02 (Claim Status Code) will be 22 (Reversal of Previous Payment). If the payment due to the pharmacy is not sufficient to cover the full amount of a claim reversal, a refund request letter will be sent to the pharmacy within 30 days. Pharmacies requiring a claim reversal which exceeds 30 days from the date of service should contact the Programs' Fiscal Unit at **1-800-732-9503** to process a recoupment of payment.

MANUAL CLAIMS

Late claims and reversals submitted manually **must** be accompanied by a letter of explanation detailing why the claim could not be submitted timely and/or electronically. On rare occasions, ADAP will direct the pharmacy to submit a manual claim. No other manual claims will be accepted unless the date of service is greater than 14 days, but less than 90 days, and a letter explaining why the claim was not submitted through the Point of Sale system is provided to ADAP. Manual

claims submitted more than 90 days from the dispensing date will be denied. Bulk submissions of manual claims will not be processed.

Submit all claims to:

UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052

Questions regarding claim submission or dispensing medications to ADAP participants may be referred to the Programs' provider line at **1-800-832-5305**. If you are calling from outside of New York State, please call **1-518-459-1641**.

CLAIM DENIALS

When a claim is denied, verify the denial code to determine if a data entry error has occurred. ADAP utilizes prospective and retrospective utilization review interventions. Prospective reviews may cause claim denials. Each time a claim is submitted, a series of edits are performed:

- Provider eligibility verification including EPIC enrollment;
- Client eligibility verification including Date of Birth and complete 11-digit identification number;
- Verification of NDC to determine if the medication is covered;
- Determination of prescription refill period (refill denied unless a minimum of 75 percent of the last days' supply period has occurred);
- Quantity verification to insure monthly maximum is not exceeded;
- Number of days supply the program standard limit is 30 days;
- Maximum Anti-Retroviral/Protease Inhibitor Combination;
- Antiretroviral combinations deemed to be sub-optimal or contra-indicated;
- Determination if third-party or Medicare Part D coverage exists (other coverage must be utilized as primary payer); and
- Determination of prior approval requirement (some medications require prior approval - claim denied if submitted without first receiving prior approval).

Retrospective utilization reviews may result in a comprehensive audit and/or recovery of overpayments (see section below). Existing reviews include, but are not limited to:

- Automatic refills or excessive submission of early refills;
- Appropriate coordination of benefit (COB) billing: ADAP reviews COB claims billed to ADAP. The analysis compares the coordination of billing versus insurance payments received by the pharmacy. ADAP seeks recoveries for all overpayments;
- Out of state shipping: Participants **must** reside within New York State. Prescriptions may not be shipped to non-New York State addresses unless the shipment has been previously approved.

PROGRAM POLICY/PROCEDURE UPDATES

All pharmacy policy/procedure updates will be sent to pharmacy providers electronically via email. To ensure proper billing and claim adjudication, all pharmacies are required to maintain at least one active email address in the ADAP pharmacy provider database. This email address should be the general or primary email address for your pharmacy. A personal email address for the supervising pharmacist may be provided as a secondary address or if the pharmacy does not have a general email address.

Current versions of this Pharmacy Provider Manual can be downloaded from the NYC DOH website:
http://www.health.ny.gov/diseases/aids/resources/adap/manuals/docs/pharmacy.pdf

PROBLEMS, COMPLAINTS, AND BILLING ISSUES

If you have a problem with payment or other administrative aspects of ADAP, please contact the Assistant Director at **1-518-459-1641,** or write to the Programs at:

Uninsured Care Programs
EMPIRE STATION
P.O.BOX 2052
ALBANY, NY 12220-0052

CONFIDENTIALITY

As an ADAP provider, it is essential that you are sensitive to the need of ADAP participants to have their prescriptions filled with complete confidentiality.

The Uninsured Care Programs, ADAP require that all pharmacy staff observe the highest standards of confidentiality in providing services. The Health Care Portability and Accountability Act (HIPAA) defines personal identifiers and requires a detailed notice of privacy practices be given to patients upon enrollment into the Programs and at least once every three years thereafter. HIPAA also holds the provider accountable for non-specifically authorized disclosures. State Education Law as it relates to professional licensing specifically prohibits revealing personally identifiable facts, data or other information obtained in a professional capacity without the prior consent of the patient except as authorized by law.

UTILIZATION REVIEW, RECORD KEEPING, AUDIT AND CLAIM REVIEW

Record-Keeping Requirements

Federal Law and State Regulations require providers to maintain financial and health records necessary to fully disclose the extent of medications and supplies provided to ADAP participants. Pharmacy providers must furnish information regarding any payment claimed to authorized officials upon request of the State Department of Health. All claims made under ADAP shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the date of payment. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this part.

For audit purposes, records on participants must be maintained and be available to authorized Uninsured Care Programs officials for six years following the date of payment. Failure to conform to these requirements may affect payment and may jeopardize a provider's eligibility to continue as an ADAP provider.

Unacceptable Practice

An unacceptable practice is conduct by a person which conflicts with any of the policies, standards or procedures of the State of New York or federal statute or regulation which relates to the provision of medication and or the fiscal integrity of the Programs. Examples of unacceptable practices include, but are not limited to the following:

- Knowingly making a claim for an improper amount or for unfurnished, unnecessary medications or supplies;
- Practicing a profession fraudulently beyond its authorized scope, including the provision of medications or supplies while one's license to practice is suspended or revoked;
- Failing to maintain records necessary to fully disclose the extent of the medications or supplies furnished;

- Soliciting, receiving, offering or agreeing to make any payment for the purpose of influencing an ADAP participant to either utilize or refrain from utilizing any particular source of medication or supplies; and
- Knowingly demanding or collecting any compensation in addition to claims made under ADAP.

Audit and Claim Review

(a) Providers shall be subject to audit by the Department of Health or its designees. With respect to such audits, the provider may be required:

1. To reimburse the Department for overpayments discovered by audits; and
2. To pay restitution for any direct or indirect monetary damage to the Programs resulting from improperly or inappropriately furnishing covered services.

(b) The Department of Health may conduct audits and claim reviews and investigate potential fraud or abuse in a provider's conduct. The Department of Health may pay or deny claims or delay claims for audit review.

(c) When audit findings indicate that a pharmacy has provided covered services in a manner which may be inconsistent with regulations governing the Programs, or with established standards for quality, or in an otherwise unauthorized manner, the Department of Health may summarily suspend a provider's participation in ADAP and/or payment of all claims submitted and all future claims may be delayed or suspended. When claims are delayed, or suspended, a notice of withholding payment or recoupment shall be sent to the pharmacy by the department. This notice shall inform the provider that within 30 days he/she/they may request in writing an administrative review of the audit determination before a designee of the Department of Health. The review must occur and a decision rendered within a reasonable time after a request for recoupment is warranted, or if no request for review is made by the provider within the 30 days provided, the department shall continue to recoup or withhold funds pursuant to the audit determination.

(d) Where investigation indicates evidence of abuse by a provider; the provider may be fined and/or suspended, restricted or terminated from the Programs.

Audits and Recovery of Overpayments

(a) Recovery of overpayments shall be made only upon a determination by the Department of Health that such overpayments have been made. Recovery shall be made of all money paid to the provider to which it has no lawful right or entitlement.

(b) Recovery of overpayments pursuant to this subject shall not preclude the Department of Health or any other authorized governmental body or agency from taking any other action with respect to the provider, including auditing or reviewing other payments or claims for payment for the same or similar periods, imposing program sanctions or taking any other action authorized by law.

(c) The Department of Health may utilize any lawful means to recover overpayments, including civil lawsuit, participation in a proceeding in bankruptcy, common law settlement, or such other actions or proceedings authorized or recognized by law.

(d) All records supporting claim payment or recovery which are used for the purpose of establishing or supporting the providers right to payment under ADAP shall be subject to audit. All underlying books, records and documentation including all covered services provided shall be kept and maintained by the provider for a period of not less than six years from the date of payment or recovery.

(e) All claims made under ADAP shall be subject to audit by the Department of Health, its agents or designees, for a period of six years from the date of payment. Time frame limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the performance of an audit pursuant to this Part.

Fraud

Examples of fraud include when a person knowingly:

- Makes a false statement or representation which enables any person to obtain medical services to which he/she/they is not entitled;
- Presents for payment any false claim for furnishing services or merchandise;
- Submits false information for the purpose of obtaining greater compensation than that to which he/she/they is legally entitled;
- Submits false information for the purpose of obtaining authorization for the provision of services or merchandise.

Termination - Disenrollment

Either the Uninsured Care Programs or the pharmacy may terminate a pharmacy's ADAP enrollment with 30 days written notice. The Programs reserve the right to terminate or suspend pharmacies with less than 30 days written notice for any of the following unacceptable practices:

- Violation of participant confidentiality;
- Fraud;
- Failure to comply with audit requirements;
- Failure to maintain an active email address for the pharmacy;
- Failure to maintain EPIC and New York State Medicaid enrollment.

NEW YORK STATE DEPARTMENT OF HEALTH
UNINSURED CARE PROGRAMS
ADAP SPECIFICATIONS FOR NCPDP D.Ø TRANSACTIONS

Part 1 – Request Transaction Segments

CLAIM BILLING/CLAIM REBILL REQUEST

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

GENERAL INFORMATION

Payer Name **Uninsured Care Programs** (NYS ADAP)	Date: 9/1/2020	
Plan Name/Group Name: **ADAP as Primary/Secondary** ⟶	BIN: **610490**	PCN: **ADAP01**
Plan Name/Group Name: **ADAP as Secondary to Part D** ⟶	BIN: **610490**	PCN: **TROOPUCP**
Processor: NYS ADAP		
Effective as of: 09/21/2020	NCPDP Telecommunication Standard Version/Release #: D.Ø	
NCPDP Data Dictionary Version Date: May 2020	NCPDP External Code List Version Date: May 2020	
Contact/Information Source (Provider Help Line) : **1-800-732-9503**		
Certification Testing Window: NA		
Certification Contact Information: NA		
Provider Relations Help Desk Info: 1-518-459-1641		
Other versions supported:		

OTHER TRANSACTIONS SUPPORTED

Payer: *Please list each transaction supported with the segments, fields, and pertinent information on each transaction.*

Transaction Code	Transaction Name
E1	Eligibility Only
B2	Claim Reversal

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	**M**	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	**R**	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	**RW**	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

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

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

	Transaction Header Segment			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	610490	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	ADAP 01 TROOPUCP	M	Use TROOPUCP for Medicare Part D transactions, use ADAP01 for all others.
1Ø9-A9	TRANSACTION COUNT	01 = 1 02 = 2 03 = 3 04 = 4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	01 is the only value accepted
2Ø1-B1	SERVICE PROVIDER ID	Provider NPI Number	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Not used

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

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	NYS ADAP ID Number from card – see notes

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

	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH		R	Required for all claims

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, *Payer Situation*
This Segment is always sent	X	
This payer supports partial fills	X	
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide:* For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	Pharmacy-assigned RX Number
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 = NDC	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	11-Digit NDC
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER		RW	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE		RW	*Imp Guide:* Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER	00 = New Prescription 01 = First Refill 02 = Second Refill 03 = Third Refill 04 = Fourth Refill 05 = Fifth Refill	R	NYS ADAP allows a maximum of 5 refills.

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	1 = Not Compound	R	Compound prescriptions not accepted.
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	*Imp Guide:* Required if necessary for plan benefit administration. Rx date must be less than six months old and the first fill (fill number 00) must occur within 60 days of the rx date.
415-DF	NUMBER OF REFILLS AUTHORIZED		R	*Imp Guide:* Required if necessary for plan benefit administration.
419-DJ	PRESCRIPTION ORIGIN CODE	All code values are accepted.	R	
460-ET	QUANTITY PRESCRIBED		RW	*Imp Guide:* [1] Required when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document). *Payer Requirement:* • Effective 09/21/2020, field is required for Schedule II drugs
3Ø8-C8	OTHER COVERAGE CODE	All code values are supported.	RW	*Imp Guide:* Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. *Payer Requirement:* Required when other insurance coverage exists.
454-EK	SCHEDULED PRESCRIPTION ID NUMBER		R	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* NYS ADAP requires the Prescription Pad Serial Number from the Official NYS Prescription blank. When the following scenarios exist, use the following values in lieu of reporting the Official Prescription Form Serial Number: • Prescriptions received via Fax or electronically, use EEEEEEEE. • Prescriptions written by Out of State Prescribers, use ZZZZZZZZ. • Oral Prescriptions, use 99999999
343-HD	DISPENSING STATUS	P = Partial Fill C = Partial Fill Completion	RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription. *Payer Requirement:* Required for all partial fill transactions.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	*Imp Guide:* Required for the partial fill or the completion fill of a prescription.

[1] Clarifications that affect the Telecommunication Standard Implementation Guide Version D.0 are cited in the *Telecommunication Version D and Above Questions, Answers and Editorial Updates*.

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

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	Required for NYS ADAP
412-DC	DISPENSING FEE SUBMITTED		R	*Imp Guide:* Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement.
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	*Imp Guide:* Required if needed for receiver claim/encounter adjudication. *Payer Requirement:* Required

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

	Pharmacy Provider Segment Segment Identification (111-AM) = "Ø2"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
465-EY	PROVIDER ID QUALIFIER	05 = NPI	R	*Imp Guide:* Required if Provider ID (444-E9) is used.
444-E9	PROVIDER ID		R	*Imp Guide:* Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* NYS ADAP requires the NPI of the dispensing pharmacist.

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

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	01 = NPI	R	*Imp Guide:* Required if Prescriber ID (411-DB) is used. *Payer Requirement:* NYS ADAP requires 01 (NPI).
411-DB	PRESCRIBER ID		R	*Imp Guide:* Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* NYS ADAP requires the prescriber NPI number.

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claim Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	All code set values supported	M	
339-6C	OTHER PAYER ID QUALIFIER		RW	*Imp Guide:* Required if Other Payer ID (34Ø-7C) is used.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide:* Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement:* Required when another payer has adjudicated the claim.
443-E8	OTHER PAYER DATE		RW	*Imp Guide:* Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement:* Required when another payer has adjudicated the claim.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	*Imp Guide:* Required if Other Payer Amount Paid Qualifier (342-HC) is used. *Payer Requirement:* Required when another payer has adjudicated the claim.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	All code set values supported	RW	*Imp Guide:* Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement:* Required when another payer has adjudicated the claim.
431-DV	OTHER PAYER AMOUNT PAID		RW	*Imp Guide:* Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. *Payer Requirement:* Required when another payer has adjudicated the claim.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Other Payer Reject Code (472-6E) is used.
472-6E	OTHER PAYER REJECT CODE		RW	*Imp Guide:* Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
				Payer Requirement: (any unique payer requirement(s))
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER		RW	*Imp Guide:* Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement:* Required when reporting Deductible, Coinsurance, or Co-pay amounts.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide:* Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required when reporting Deductible, Coinsurance, or Co-pay amounts.
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.	RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Required when reporting benefit stage information.
393-MV	BENEFIT STAGE QUALIFIER		RW	*Imp Guide:* Required if Benefit Stage Amount (394-MW) is used. *Payer Requirement:* Required when reporting benefit stage information.
394-MW	BENEFIT STAGE AMOUNT		RW	*Imp Guide:* Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. *Payer Requirement:* Required when reporting benefit stage information.

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

ELIGIBILITY VERIFICATION REQUEST

** Start of Request Eligibility Verification (E1) Payer Sheet **

ELIGIBILITY VERIFICATION TRANSACTION

The following lists the segments and fields in an Eligibility Verification Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø.*

Transaction Header Segment Questions	**Check**	**Eligibility Verification Request** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (11Ø-AK) is Not used	X	

	Transaction Header Segment			**Eligibility Verification Request**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

	Transaction Header Segment			Eligibility Verification Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	610490	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	ADAP 01 TROOPUCP	M	
1Ø9-A9	TRANSACTION COUNT	01 = 1	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = National Provider ID	M	01 is the only value accepted
2Ø1-B1	SERVICE PROVIDER ID	Provider NPI Number	M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank fill	M	Not used

Insurance Segment Questions	Check	Eligibility Verification Request If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Eligibility Verification Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	NYS ADAP ID Number from card – see notes

Patient Segment Questions	Check	Eligibility Verification Request If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational		

	Patient Segment Segment Identification (111-AM) = "Ø1"			Eligibility Verification Request
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH		R	Required

** End of Request Eligibility Verification (E1) Payer Sheet *

CLAIM REVERSAL REQUEST

** Start of Request Claim Reversal (B2) Payer Sheet **

CLAIM REVERSAL TRANSACTION

The following lists the segments and fields in a Claim Reversal Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

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

	Transaction Header Segment			Claim Reversal Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	610490	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø4-A4	PROCESSOR CONTROL NUMBER	ADAP01 TROOPUCP	M	Use TROOPUCP for Medicare Part D transactions, use ADAP01 for all others.

	Transaction Header Segment			Claim Reversal Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø9-A9	TRANSACTION COUNT	01 = 1 02 = 2 03 = 3 04 = 4	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01 = NPI	M	
2Ø1-B1	SERVICE PROVIDER ID	Service Provider NPI	M	NPI is the only ID accepted
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Blank Fill.	M	

Insurance Segment Questions	Check	Claim Reversal Request If Situational, *Payer Situation*
This Segment is always sent	X	

	Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Reversal Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	NYS ADAP ID Number from card – see notes

Claim Segment Questions	Check	Claim Reversal Request If Situational, *Payer Situation*
This Segment is always sent	X	

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Reversal Request
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RX Billing	M	*Imp Guide:* For Transaction Code of "B2", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Pharmacy-assigned RX ID number	M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	03 = NDC	M	
4Ø7-D7	PRODUCT/SERVICE ID		M	11- digit NDC number

** End of Request Claim Reversal (B2) Payer Sheet **

Part 2 - ADAP Response Segments

CLAIM BILLING/CLAIM REBILL/ELIGIBILITY REJECTED/REJECTED RESPONSE

** Start of Response Claim Billing/Claim Rebill/Eligibility (B1/B3/E1) Rejected/Rejected Payer Sheet **

CLAIM BILLING/CLAIM REBILL/ ELIGIBILITY REJECTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill/Eligibility Rejected/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Billing/Claim Rebill/Eligibility Rejected/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3, E1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	R = Rejected	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

	Response Status Segment **Segment Identification (111-AM) = "21"**			**Claim Billing/Claim Rebill/Eligibility Rejected/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction.
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		R	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	R	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		R	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		R	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER		R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

** End of Response Claim Billing/Claim Rebill/Eligibility (B1/B3/E1) Rejected/Rejected Payer Sheet **

CLAIM BILLING/CLAIM REBILL ACCEPTED/PAID (OR DUPLICATE OF PAID) RESPONSE

** Start of Response Claim Billing/Claim Rebill (B1/B3) Accepted/Paid (or Duplicate of Paid) Payer Sheet **

CLAIM BILLING/CLAIM REBILL PAID (OR DUPLICATE OF PAID) RESPONSE

The following lists the segments and fields in a Claim Billing or Claim Rebill response (Paid or Duplicate of Paid) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	P=Paid D=Duplicate of Paid	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:* NYS ADAP will return the unique claim authorization number.

Response Claim Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response Pricing Segment Questions	Check	Claim Billing/Claim Rebill Accepted/Paid (or Duplicate of Paid) If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Pricing Segment Segment Identification (111-AM) = "23"			Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø5-F5	PATIENT PAY AMOUNT		R	NYS ADAP will return the co-pay amount due. If the member is co-pay exempt, zeros will be returned.
5Ø6-F6	INGREDIENT COST PAID		R	
5Ø7-F7	DISPENSING FEE PAID		R	*Imp Guide:* Required if this value is used to arrive at the final reimbursement.
566-J5	OTHER PAYER AMOUNT RECOGNIZED		RW	*Imp Guide:* Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero (Ø) and Coordination of Benefits/Other Payments Segment is supported.
5Ø9-F9	TOTAL AMOUNT PAID		R	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION		R	*Imp Guide:* Required if Ingredient Cost Paid (5Ø6-F6) is greater than zero (Ø). Required if Basis of Cost Determination (432-DN) is submitted on billing.
518-FI	AMOUNT OF COPAY		R	*Imp Guide:* Required if Patient Pay Amount (5Ø5-F5) includes copay as patient financial responsibility. *Payer Requirement:* NYS ADAP will return the co-pay amount due. If the member is co-pay exempt, zeros will be returned.

	Response Pricing Segment **Segment Identification (111-AM) = "23"**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
346-HH	BASIS OF CALCULATION—DISPENSING FEE	02 = Quantity Intended 04 = Waived Due to Partial	RW	*Imp Guide:* Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement:* Used for partial fills.
347-HJ	BASIS OF CALCULATION—COPAY	02 = Quantity Intended 04 = Waived Due to Partial	RW	*Imp Guide:* Required if Dispensing Status (343-HD) on submission is "P" (Partial Fill) or "C" (Completion of Partial Fill). *Payer Requirement:* Used for partial fills.

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill** **Accepted/Paid (or Duplicate of Paid)** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	This segment is sent when there is a DUR reject or if the claim is paid but there are DUR warning messages.

	Response DUR/PPS Segment **Segment Identification (111-AM) = "24"**			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	R	*Imp Guide:* Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		R	*Imp Guide:* Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		R	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		Rw	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
532-FW	DATABASE INDICATOR		Rw	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		Rw	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		Rw	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.

** End of Response Claim Billing/Claim Rebill (B1/B3) Accepted/Paid (orDuplicate of Paid) Payer Sheet **

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

** Start of Response Claim Billing/Claim Rebill (B1/B3) Accepted/Rejected Payer Sheet **

CLAIM BILLING/CLAIM REBILL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1, B3	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER			*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:* ADAP unique transaction tracking number.
51Ø-FA	REJECT COUNT	Maximum count of 20.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		RW	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER			*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER			*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

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

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B1", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

Response DUR/PPS Segment Questions	**Check**	**Claim Billing/Claim Rebill Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Sent when there is a DUR reject code.

	Response DUR/PPS Segment Segment Identification (111-AM) = "24"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
567-J6	DUR/PPS RESPONSE CODE COUNTER	Maximum 9 occurrences supported.	R	*Imp Guide:* Required if Reason For Service Code (439-E4) is used.
439-E4	REASON FOR SERVICE CODE		R	*Imp Guide:* Required if utilization conflict is detected.
528-FS	CLINICAL SIGNIFICANCE CODE		R	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
529-FT	OTHER PHARMACY INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
53Ø-FU	PREVIOUS DATE OF FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Quantity of Previous Fill (531-FV) is used.
531-FV	QUANTITY OF PREVIOUS FILL		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict. Required if Previous Date Of Fill (53Ø-FU) is used.
532-FW	DATABASE INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
533-FX	OTHER PRESCRIBER INDICATOR		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.
544-FY	DUR FREE TEXT MESSAGE		RW	*Imp Guide:* Required if needed to supply additional information for the utilization conflict.

** End of Response Claim Billing/Claim Rebill (B1/B3) Accepted/Rejected Payer Sheet **

ELIGIBILITY ONLY RESPONSE (TRANSMISSION ACCEPTED / TRANSACTION APPROVED)

** Start of Response Eligibility Only (E1) Transmission Accepted / Transaction Approved Payer Sheet **

ELIGIBILITY ONLY – ACCEPTED RESPONSE

The following lists the segments and fields in an Eligibility Only Response (Approved or Duplicate of Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	**Check**	**Eligibility Verification Response - Accepted or Duplicate of Accepted** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Eligibility Verification Only – Accepted or Duplicate of Accepted**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Eligibility Verification Response - Accepted or Duplicate of Accepted** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill – Accepted/Paid (or Duplicate of Paid)**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A= Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:* NYS ADAP will return the unique transaction tracking number.

** End of Response Eligibility Only (E1) Transmission Accepted / Transaction Approved Payer Sheet **

ELIGIBILITY ONLY RESPONSE (TRANSMISSION ACCEPTED / TRANSACTION REJECTED)

** Start of Response Eligibility Only (E1) Transmission Accepted / Transaction Rejected Payer Sheet **

ELIGIBILITY ONLY – REJECTED RESPONSE

Response Transaction Header Segment Questions	**Check**	**Eligibility Verification Response - Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	E1	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	**Check**	**Eligibility Verification Response - Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Billing/Claim Rebill Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Billing/Claim Rebill Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
5Ø3-F3	AUTHORIZATION NUMBER			*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:* ADAP unique transaction tracking number.
51Ø-FA	REJECT COUNT	Maximum count of 20.	R	
511-FB	REJECT CODE		R	
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 5.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used.
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

** End of Response Eligibility Only (E1) Transmission Accepted / Transaction Rejected Payer Sheet **

CLAIM REVERSAL ACCEPTED/APPROVED OR DUPLICATE OF APPROVED RESPONSE

** Start of Claim Reversal Response (B2) Payer Sheet **

CLAIM REVERSAL ACCEPTED/APPROVED RESPONSE

The following lists the segments and fields in a Claim Reversal response (Approved) Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.Ø*.

Response Transaction Header Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Approved
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Approved
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Approved
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	A = Approved S = Duplicate of Approved	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	*Imp Guide:* Required if needed to identify the transaction. *Payer Requirement:* Unique ADAP transaction tracking number.

Response Claim Segment Questions	Check	Claim Reversal – Accepted/Approved If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			Claim Reversal – Accepted/Approved
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

** End of Claim Reversal Response (B2) Payer Sheet **

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

** Start of Claim Reversal Response (B2) Payer Sheet **

CLAIM REVERSAL ACCEPTED/REJECTED RESPONSE

Response Transaction Header Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Transaction Header Segment			Claim Reversal – Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B2	M	
1Ø9-A9	TRANSACTION COUNT	Same value as in request	M	
5Ø1-F1	HEADER RESPONSE STATUS	A = Accepted	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Same value as in request	M	
2Ø1-B1	SERVICE PROVIDER ID	Same value as in request	M	
4Ø1-D1	DATE OF SERVICE	Same value as in request	M	

Response Status Segment Questions	Check	Claim Reversal - Accepted/Rejected If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Status Segment Segment Identification (111-AM) = "21"			Claim Reversal – Accepted/Rejected
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
112-AN	TRANSACTION RESPONSE STATUS	R = Reject	M	
5Ø3-F3	AUTHORIZATION NUMBER		R	
51Ø-FA	REJECT COUNT	Maximum count of 5.	R	
511-FB	REJECT CODE		R	
546-4F	REJECT FIELD OCCURRENCE INDICATOR		R	*Imp Guide:* Required if a repeating field is in error, to identify repeating field occurrence.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Maximum count of 25.	RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.

	Response Status Segment Segment Identification (111-AM) = "21"			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER		RW	*Imp Guide:* Required if Additional Message Information (526-FQ) is used.
526-FQ	ADDITIONAL MESSAGE INFORMATION		RW	*Imp Guide:* Required when additional text is needed for clarification or detail.
131-UG	ADDITIONAL MESSAGE INFORMATION CONTINUITY		RW	*Imp Guide:* Required if and only if current repetition of Additional Message Information (526-FQ) is used, another populated repetition of Additional Message Information (526-FQ) follows it, and the text of the following message is a continuation of the current.
549-7F	HELP DESK PHONE NUMBER QUALIFIER	03 = Processor/PBM	R	*Imp Guide:* Required if Help Desk Phone Number (55Ø-8F) is used. *Payer Requirement:* ADAP Help Desk Number.)
55Ø-8F	HELP DESK PHONE NUMBER		R	*Imp Guide:* Required if needed to provide a support telephone number to the receiver.

Response Claim Segment Questions	**Check**	**Claim Reversal - Accepted/Rejected** If Situational, *Payer Situation*
This Segment is always sent	X	

	Response Claim Segment Segment Identification (111-AM) = "22"			**Claim Reversal – Accepted/Rejected**
Field #	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = RxBilling	M	*Imp Guide:* For Transaction Code of "B2", in the Response Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	

** End of Claim Reversal Response (B2) Payer Sheet **

Questions Should Be Directed to:

UNINSURED CARE PROGRAMS
EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220

Inside New York State - (800) 732-9503
Outside New York State – (518) 459-1641
adap@health.state.ny.us

UNINSURED CARE PROGRAMS
Troubleshooting Guide to Online Claims Processing
Common Error Codes and Corrective Actions

Code: M1 **Patient Not Covered in this Aid Category**

Explanation: An incorrect PCN was entered when processing the claim (linked to Code: 04).

Correction: Enter the correct PCN. The pharmacy was sent the correct number via text to field 526-FQ.

Code: M2 **Recipient Locked In**

Explanation: The participant is restricted to a single pharmacy and the claim is not from that pharmacy.

Correction: Call ADAP to confirm restriction. Instruct the participant go to assigned pharmacy. In certain situations, ADAP may change or remove the restriction.

Code: M4 **Prescription Number/Time Limit Exceeded**

Explanation: ADAP will pay for a total of five concurrent antiretroviral medications with no more than two of these being protease inhibitors.

Correction: This error can occur when claims are received for more than five concurrent antiretroviral medications. In some cases, there has been a regimen change and the pharmacist will need to verify the patient's *current* regimen. Once the regimen has been confirmed, pharmacists can call 800-732-9503 and an ADAP pharmacy representative will make the corrections in the ADAP concurrent treatment system allowing the new claim to go through. Low dose Norvir and Kaletra as part of an ARV regimen can be overridden by an ADAP pharmacy representative if it puts the regimen over the limit. In other cases, a physician has deemed that more than five full dose antiretrovirals are required. The prescribing physician must sign an Exception to ADAP Antiretroviral Combination Limit form. Once this form is received by ADAP, an entry will be made in the ADAP concurrent treatment system that will allow more than five antiretroviral drugs for a given period.

Code: 04 **Invalid/Missing PCN**

Explanation: An incorrect PCN was entered when processing the claim (linked to Code: M1).

Correction: Enter the correct PCN. The pharmacy was sent the correct number via text to field 526-FQ.

Code: 07 **Invalid/Missing Cardholder ID Number**

Explanation: This code is generated when the incorrect cardholder ID number is entered.

Correction: Ask the participant for their most recent ADAP eligibility card. Be sure to omit the dashes and use the format: 99999999ØA.

Code: 09 **Invalid/Missing Date of Birth**

Explanation: This code is generated when the date of birth field is missing or does not match the date of birth on file with ADAP.

Correction: Ask the participant for their date of birth. If this does not match the participant must contact ADAP.

Code: 17 **Invalid/Missing Refill Date**

Explanation: The first fill of a new prescription must be entered as refill 0.

Correction: Enter "0" as the refill number

Code: 19 **Missing/Invalid Days Supply**

Explanation: This code is generated when the days supply field (NCPDP # 405) is blank or is greater than 30 days (100 days in the case of vitamins or supplements).

Correction: Adjust the days supply to fit within ADAP limits where applicable, otherwise, an extended supply approval is required. A 90 day extended supply can be approved without written justification. Requests for an extended supply beyond 90 days or for a subsequent extended supply require a written justification.

Code: 25 **Missing/Invalid Prescriber ID**

Explanation: All claims require a valid NPI number in the prescriber ID field (NCPDP # 411).

Correction: Enter a valid NPI number.

Code: 28 **Missing/Invalid Date Prescription Written**

Explanation: The first fill of a new prescription must occur within 60 days from the date on the prescription.

Correction: Verify that the correct date has been entered. If the prescription date is past the 60 day allowable window, contact the doctor's office for a new prescription.

Code: 41 **Submit Bill to Other Processor or Primary Payer**

Explanation: This code is generated when an individual has other coverage in addition to ADAP (Health Insurance, Medicare Part D, Medicaid spenddown). ADAP is considered secondary or tertiary payer to other coverage.

Correction: Bill the other coverage first, then ADAP.

Code: 65 **Patient Is Not Covered**

Explanation: Individual is not covered by ADAP on the date of service.

Correction: Call ADAP to verify eligibility.

Note: Many individuals are terminated from ADAP once they become eligible for Medicaid. Verify Medicaid eligibility and bill Medicaid if approved.

Code: 70 **NDC Not Covered**

Explanation: **This error code does not indicate that a drug is not covered by ADAP**. NDC codes are specific to a medication manufacturer, dosage, and package size. A code 70 is generated when an active price for an NDC is not located in the ADAP system. This code is often generated in conjunction with a code 54 (Non-Matched NDC Number).

Correction: Call ADAP to verity that the drug is not covered.

Code: 75 **Prior Authorization Required**

Explanation: A number of medications covered by ADAP require prior approval before dispensing. Medications requiring prior approval are indicated on the ADAP Formulary. A current Formulary can be found the Department of Health website: **http://www.nyhealth.gov/diseases/aids/resources/adap/formulary.htm**

Correction: Prescribing physician must sign a Prior Authorization Request form or use the automated prior authorization phone line for some drugs. Prior authorizations for Mepron (atovaquone), Fuzeon (enfuviritide), and Aptivus (tipravavir) can be obtained by calling 800-732-9503. For other prior authorizations a Prior Authorization Form must be requested. When this form is received by ADAP, an entry will be made in the prior approval system that will approve the medication for a given time period.

Code: 76 **Plan Limitations Exceeded**

Explanation: The quantity of all medications and devices is limited to a maximum supply for a 30 day period. This limit is prorated based on the days supply field (NCPDP # 405). The quantity of the drug or device dispensed divided by the days supply cannot exceed the maximum daily limit.

Correction: The days supply field may be adjusted to fall within ADAP limits. However, a physician may deem that it is clinically necessary to exceed ADAP limits. In this case, the physician must sign a Medication Limit Override form. Once this form is received by ADAP, an entry will be made in the drug limit override system that will allow a new limit for a designated participant for a specified time period.

Code: 79 **Early Refill**

Explanation: A prescription cannot be refilled until 75 percent of the supply has been used.

Correction: A reasonable justification for an early refill is required. This may include a dispensing error, lost or damaged prescription or a patient use error. An entry will be made in the ADAP early refill system that will allow a refill for a designated participant for the specified NDC on a given day.

Code: 88 **DUR Reject Error**

Explanation: Needles/syringes require an approved claim for an injectable medication within one day prior to the claim. Antiretroviral combinations deemed to be sub-optimal or contra-indicated will also generate a DUR error.

Correction: If dispensing an injectable medication and syringe at the same time, submit the medication first. If no injectable medication is being dispensed, a needle/drug proximity override is required. If a needle/drug proximity override is required, call ADAP. In the case of a sub-optimal ARV DUR error, please contact the ADAP pharmacy hotline at 1-800-732-9503.

Code: ET **Missing/Invalid Quantity Prescribed**

Explanation: For the period on and after September 21, 2010, the Quantity Prescribed (460-ET) field is required where the transmission meets both of the following for a Schedule II drug, as defined in 21 CFR 1308.12.

Correction: The Quantity Prescribed (460-ET) is a required field for Schedule II prescription claims.

Questions regarding claim rejections should be directed to:

From within New York State: **(800) 732-9503**