

Frequently Asked Questions about Billing and Payment/Reconciliation Files

(NCPDP Work Group 1, Telecommunications, maintains the Billing Standards)

Q. Which Claim or Payment format do I use for what?

A. This is generally a trading partner issue. There are currently four (4) payment standards (NCPDP Claims Billing Tape format Version 1.0, Claims Billing Tape format Version 2.0, Payment Reconciliation format Version 3.0 and the Mapping Guide ASC X12N 835 version 4010 which WG5 is currently working on). There are also numerous proprietary formats in use.

Claims Billing Tape format Version 1.0, while still in use by some, is not Y2K compliant. Claims Billing Tape format Version 2.0 is the most widely used format within the industry and has been customized by many organizations to accommodate trading partner needs.

By October 16, 2002 HIPAA has mandated the use of the ASC X12N 835 version 4010 reconciliation for transferring payment information between trading partners. WG5 is currently completing the mapping of the NCPDP Payment Reconciliation Version 3.0 format to this format.

Updated response (11/02/05): The X12 835 v.4010A1 is the HIPAA mandated format for payment reconciliation. Please refer to Work Group 1, Telecommunication, for billing information (www.ncpdp.org)

Q. How many Batch Billing formats are there and which do I use for what?

A. This is generally a trading partner issue that should be discussed in order to find the most economical method of transferring billing information. There are currently three (3) billing standards that are in use by NCPDP members (Claims Billing Tape format Version 1.0 and Version 2.0 and Batch Transaction Standard Version 1.1).

The Claims Billing Tape format Version 1.0 and 2.0 are included in the same document with the Payment Tape formats Version 1.0 and 2.0.

The Batch Standard Version 1.1, used for billing is actually a header and trailer record for the NCPDP Telecommunication Standard Version 3.2 or Telecommunication Standard Version 5.

There is an ASC X12N 837 format that is used by a few in the industry and there are numerous proprietary formats in use. Which version you use is again a trading partner issue.

The Billing Tape format Version 2.0 is currently the most commonly used batch format for billing pharmacy claims. For claims billing of retail pharmacy, HIPAA has mandated that by October 16, 2002 the Batch Standard Version 1.1 be used and that version 5.1 of the NCPDP Telecommunication Standard for billing pharmacy claims online be used.

Updated response (11/02/05): Batch Standard v1.1 is the only standard approved by HIPAA Please refer to Work Group 1, Telecommunication, for billing information

Q. Should I move to the ANSI X12 835 version 4010?

A. This is a trading partner issue but in general the answer is yes. HIPAA requires that the industry begin using this format no later than October 16, 2002 (2003 for small health plans \$5M/yr). It is anticipated that some organizations will begin rolling out this version for testing and implementation starting around August 12, 2001. The required date for implementation is October 16, 2002 or October 16, 2003 for small health plans.

Updated response (11/02/05): HIPAA requires that the industry begin using the X12 835 v4010A1 format no later than October 16, 2002.

Q. What is the difference between the Claims Billing Tape format Version 1.0, Claims Billing Tape Version 2.0 and the NCPDP Batch Transaction Standard Version 1.1?

A. The Claims Billing Tape Version 1.0 Billing Tape format was the first standard developed for the submission of batch transactions to payers for pharmacy claims adjudication. In 1993 NCPDP approved Version 2.0 of the Payment and Billing Tape formats.

In 1999, NCPDP approved the Batch Transaction Standard Version 1.1. This format is actually to be used for the NCPDP Telecommunication Standard Version 3.2 or higher. The format consists of an envelope with a header and trailer to wrap a Telecommunication format claim. It allows the ability to use the Telecommunication fields and syntax in a claim, but to wrap it with a header and trailer to submit the claims in batch mode, rather than real-time. Updated response (11/02/05): Please refer to Work Group 1, Telecommunication, for billing information

Q. Work Group 5 (WG5) has done mapping for the ASC X12N 835 Version 3070. Should I use this format until the 4010 is completed?

A. Unless you are already using this version it is recommended that you discuss this with your trading partner(s) and/or begin preparing to use the Version 4010 of the ASC X12N 835 Standard that has been mandated by HIPAA.

Updated response (11/02/05): ASC X12 835 v4010A1 has been completed and is mandated by HIPAA. A current Mapping document is available on the WG5, Payment Reconciliation web page (www.ncpcp.org).

Q. If I am using the NCPDP Version 2.0 Billing Claim or Payment Tape format, do I need to move to something else for HIPAA? If so what?

A. HIPAA has mandated the use of the ASC X12N 835 Version 4010 for payment reconciliation. If you are using the Version 2.0 Payment Tape format you, along with your business partners, will need to begin migrating to use the HIPAA required format of ASC X12N 835 Version 4010. HIPAA has also mandated the use of NCPDP Batch Version 1.1 format when batch billing retail pharmacy claims.

Updated response (11/02/05): HIPAA has mandated the ASC X12 835 v.4010A1 format for payment reconciliation. Please see the WG1, Telecommunication, web page for information regarding the HIPAA named Batch v1.1 format.

Q. Do I need to program to the NCPDP Version 3.0 Payment Tape format first in order to go from the Version 2.0 Payment Tape format to the ASC X12N 835 Version 4010?

A. No. WG5 has mapped the NCPDP Version 3.0 Payment Reconciliation format to the ANSI X12 835 Version 4010 format because it was the most recent version. All the fields that are contained in the NCPDP Version 2.0 Payment Tape format are also found within the Version 3.0. Version 3.0 contains additional fields not in the NCPDP Version 2.0 Payment Tape format. You, and your business partner(s), can and should begin migrating directly to the ASC X12N 835 Version 4010 transaction using the mapping guide developed by WG5 to find the fields you are currently using in the Version 2.0 NCPDP Payment Tape format.

Updated response (11/02/05): No. WG5 has mapped the NCPDP v3.0 Payment Reconciliation format to the ASC X12 835 v4010A1 format because it was the most recent version.

Q. When would I use the Claims Billing format versus the Payment Tape format versus the Payment Reconciliation? What is the difference between the Payment Tape format and the Reconciliation format? Why were both created?

A. The Claims Billing format was initially developed to facilitate an electronic batch transfer of pharmacy claims to a processor. Since that time, the industry has gone to real-time online adjudication of claims and the need for using this format to bill claims has diminished. This format is also used between trading partners to transfer claim data to data warehouses, load claim history and report pharmacy encounters.

The Payment Tape format created in 1993 and the Payment Reconciliation format created in 1999 are both intended for the same purpose: to provide an electronic means to reconcile a pharmacy payment to the transactions that have been submitted online or in batch. The Payment Reconciliation Version 3.0 format was

created out of an industry need for additional data elements prior to the HIPAA announcement that the ASC X12N 835 would be required.

Updated response (11/02/05): The ASC X12 835 v4010A1 is the required format.

Q. What EDI media can I use with the 835?

A. Tape, cartridge, CD, diskette, FTP, Network Data Management (NDM), TCPIP. Updated response (11/02/05): Secured Encrypted FTP, CD, diskette, Network Data Management (NDM), TCPIP, web download, bulletin board, AS2, cartridge, tape

Q. Where do I find information on readiness for 835 implementation?

A. Contact trading partner.

Q. Are paper RA's required to contain the data content of the 835?

A. No.

Q. The 835 Implementation Guide recommends that we limit claim transactions to 10,000 claims. Will NCPDP abide by the 10,000 CPL limitations?

A. Please refer to the 835 HIPAA Implementation Guide regarding the 10,000 CLP recommendations. The Implementation Guide states that the recommendation is a maximum of 10,000 CLP segments. The Implementation Guide also states that willing trading partners can agree to set higher limits.

Note: The Transactions and Code Sets Final Rule named NCPDP Batch Standard Version 1.0. NCPDP has requested a technical correction to Batch Standard Version 1.1 (which uses Telecommunication Standard Version 5.1 in the detail record). This correction is expected to be published in a Notice of Proposed Rule Making (NPRM) in 2001.

Note: The definition of Small Health Plans is \$5 million per year.

Q. I wanted to make sure that we're in synch with how others are creating 835s, so I thought I would ask you guru/WG co-chair types about how many GS/GE loops to include on a pharmacy 835. Do you agree with the following?

1. There is 1 set of GS/GE for an affiliate 835
2. There is 1 set of GS/GE for an independent 835
3. There is 1 set of GS/GE for a chain 835

A. There is no limitation on the number of Functional Groups that may be included in any ISA/IEA iteration. Another option is to include separate ST/SE sets for each of these instances. Technically, either way will be compliant.

Q. How does one handle 835 files that exceed the maximum number of loops/lines available? If we are remitting for more than 10,000 claims on a single check, how is the 835 presented so that it still balances?

A. Please refer to 835 Implementation Guide, Section 1.2 – Transaction Limitation (page 10).

Updated response (11/02/05): Please refer to the most current 835 Implementation Guide available from the following website for free download: www.wpc-edi.com

Q. Regarding the SVC01-7, NDC description. I noticed that it is not on the NCPDP recommended 835 layout. This is questioned because the current paper RA shows the drug name. I am assuming since several big providers were part of the template discussion that they don't care about the description. Is this a correct assumption? Also, I am assuming that providers will be using the NCPDP recommended 835 layout to write programs to generate the 835 ERA. Does this mean they won't recognize segments sent that are not part of the NCPDP recommended 835 layout?

A. 1. The drug name is indeed frequently used on paper remittance advice. However, the drug name has not been used on previous NCPDP standard remittance formats. This is a response to the billing from the provider, so the provider certainly should have the NDC number on file and not require the name in an electronic remittance advice.

2. The 835 is a HIPAA mandated transaction. It is generated by payers, not providers, as your question implies. HIPAA requires recognition of all standard segments. It does not require either the provider or the payer to use these segments in their "backend" processing applications. In fact, the general rule is to use the "minimum necessary" information to process the transactions. A payer must, however, populate all required segments and fields. A provider can choose to ignore any information they choose. The purpose of the NCPDP template is to suggest an implementation strategy to payers that will result in more standard reconciliation data sets to the provider community, without needing to resort to "trading partner agreements".

Q. In reviewing the ASCX12N 835 mapping document provided by NCPDP, the N103 and N104 on the N1 Payee segment are required but not required on the N1 Payer segment. In comparing syntax the notes on the two segment from the Implementation guide it seems there are inconsistencies between the two. For example, the syntax notes on both say "At least one of the N102 or N103 is required". To me this means if I use N102 then I should not be required to populate N103/N104. The inconsistency is that the N103 and N104 on the N1 Payee segment are required but it contradicts the syntax notes. The N1 Payer segment seems okay. I want to be sure I am interpreting the X12 guide and the NCPDP mapping document correctly. Could you please clarify this for me?

A. Due to N103 and N104 not being allowed until the National Plan ID is implemented; N102 is a required field in the Payer Segment. The NCPDP/835 Mapping document has been updated to reflect this change.

Q. How do we return payment on the 835 for compounds?

A. NCPDP recommends that on an 835 response for multi-ingredient compound submissions, a single consolidated SVC segment (Loop 2110) be returned. If response is paid (i.e. any ingredient is paid), then return the NDC of the first submitted and paid ingredient in the SVC01-2. If there is no payment for the compound claim, then return the NDC of the first submitted ingredient in SVC01-2.

Q. How does a provider match money (EFT/ACH) to an Electronic Remittance detail data (835)?

A. Per HIPAA Rules, a payer must provide for a re-association via a trace number that links the payment instrument (check/EFT) to the associated 835. Scenarios for accomplishing this can be found in the current ASC X12N 835 (004010X091A1) Implementation Guide. In all EFT/ACH scenarios the payer must coordinate with its originating financial institution and the provider must coordinate with its receiving financial institution to facilitate re-association.

Q. I've run across a situation for which I can't find any guidance in the NCPDP ASCX12N 835 Mapping Document or other NCPDP documents. In v5.1, the Rx Number (Product/Service Reference Number) is numeric, so some pharmacies are truncating the leading zeros as allowed. That's no problem on processing the claim on-line. However, the field for that number in the ANSI X12N 835 transaction is defined as an A/N field, which means truncating leading zeros is not allowed.

When creating an 835 remittance for a claim submitted in 5.1, what is the appropriate thing to do with leading zeros? Always include them, omit them, or return them as submitted by the pharmacy? Always including them can cause problems when moving to v6.x since the maximum length of that field has increased. Returning them as submitted is a problem as we don't capture them as submitted, we capture them as numeric. Has WG5 addressed this?

A. The 835 should reference the same format of the Rx Number submitted on the claim.

Q. We have a question concerning the NM1 - Corrected Priority Payer Name in Loop ID – 2100 Claim Payment Information. I know this segment was not included in the NCPDP ASC X12N 835 Pharmacy Remittance Advice Template. My client would like more information on why the decision was made to not use this segment for pharmacy claims.

A. The decision was made based on the fact that the Work Group felt that most of the rejects for online transactions due to being sent to the wrong payer would most likely never show up on the 835. These would merely be online rejections.

Most of the time, the billing decision must be made while the patient is still in the pharmacy (or before they get there). The 835 is not timely enough to influence most of the "real time" billing decisions. However, there is absolutely nothing that prohibits this information from being sent on the 835 if there is a need for it. If you want to provide it, or you feel your provider community needs this information, you should go ahead and include it.

As noted in the template document, any segment/data element allowed by the ASC X12N 835 (004010X091A1) Health Care Claim Payment/Advise Implementation Guide may be included.

Q. How should the PLB segment look if there were a negative forward balance from a previous remittance and the claims in the new remittance don't completely offset the negative forward balance from before (i.e., there's still a negative balance)?

A. Here's a scenario for 3 weekly pharmacy remittances:

Payment file #1 (week 1)

- Payer is paying provider (ID=0123456) for 3 scripts - Script 1 is for \$50, Script 2 is for \$50 and Script 3 is for \$1,000. Total payment is \$1,100. Carry forward balance is \$0.

Payment file #2 (week 2)

- Payer is paying provider for 2 new scripts, but Script 3 from the previous payment/week has been reversed - Script 4 is for \$25, Script 5 is for \$75, and Script 3 from before is reversed for a value of -\$1,000. Total payment is \$0 with a carry forward balance of -\$900 (25+75-1000).

Payment file #3 (week 3)

- Payer is paying provider for 3 new scripts - Script 6 is for \$25, Script 7 is for \$100 and Script 8 is for \$25. New scripts total is \$150, but there is a carry forward balance of -\$900, so total payment is \$0 with a carry forward balance of -\$750 (-900+25+100+25).

The resulting 835 segments should show:

Payment file #1 (week 1)

BPR*I*1100*C*CHK*****20030923~
(CLP segments totaling \$1100.00 [50+50+1000])
(No PLB segments needed.)

Payment file #2 (week 2) - Assume that trace number for this payment is 98765

BPR*H*0*C*NON*****20030930~
(CLP segments totaling -\$900.00 [25+75-1000])
PLB*0123456*20031231*FB:98765*-900~

Payment file #3 (week 3) - Assume that trace number for this payment is 98876

BPR*H*0*C*NON*****20031007~
(CLP segments totaling \$150.00 [25+100+25])
PLB*0123456*20031231*FB:98765*900*FB:98876*-750~

Comment: Payment trace numbers are used as reference identifiers for the adjustment reason codes as suggested in the implementation guide for version 4050.

Q. It is my understanding that there is no place in this format for a chain check summary. Is this correct?

A. NCPDP Work Group 5 broached this subject with the X12 committee responsible for the 835. Their response was that no recap was necessary, since the numbers could be programmatically developed. A basic premise of the 835 is that all payments are mathematically balanced; therefore, you can trust the individual numbers.

Q. How should claim level manual audits be reported on the 835?

A. It is assumed the author is requesting clarification on how claim level audit chargeback's should be handled. Claim level adjustments should always be provided in the 2100 loop. The CLP01 should contain the Rx number and the CLP04 should be a value of the adjustment. The CAS segment is used to indicate the reason of the adjustment. Since specific code values related to audit charges do not exist, it is recommended adjustment codes be agreed upon via trading partner agreement between payer and provider.

Q. How should claim level desk audits be reported on the 835?

A. Claim level adjustments as a result of an audit recoupment should be provided in the 2100 loop. The CLP01 should contain the Rx number and the CLP04 should be a value of the adjustment. The CAS segment is used to indicate the reason of the adjustment. Since specific code values related to audit charges do not exist, it is recommended adjustment codes be agreed upon via trading partner agreement between payer and provider.

Q. Do claim level adjustments/reversals go in the PLB?

A. The PLB segment is for provider level adjustments not claim level specific adjustments. Therefore, the PLB segment should not be used for claim level adjustments.

Q. Where do forward balances go on the 835?

A. NCPDP recommends the following reporting of forward balances within the 835.

1. BPR01 = "I"
2. BPR02 = "check amount greater than \$0.00"
3. BPR03 = "C"

or

1. BPR01 = "H"
2. BPR02 = "\$0.00"

If the sum of the current payments and provider adjustments are less than \$0.00, NCPDP recommends that value of BPR02 = \$0.00"

3. BPR03 = "C"

The sum of the current claim payments and provider adjustments must balance to BPR02. When this does not occur due to reversals or adjustments, utilize PLB03-1 with a code of FB to adjust the BPR02 to \$0.00.

When a balance forward adjustment was reported in a previous 835, a future 835 must use the PLB03-1 (Code FB) to add that money back in order to complete the process. The PLB04 will then contain the same dollar amount as the previous 835 but as a positive value. The positive value reduces the payment in the most current 835.

Forward balances should be reported in the PLB segment on the current 835, as well as the previous 835 (for initiating) or subsequent 835 (for clearing purposes).

Please see the additional FAQ question on forward balances for a detailed example.

Q. How should a transaction fee be indicated on the 835?

A. If a transaction fee is charged for an individual claim and the value is included in CLP04, the CAS segment is used. If the transaction fee value is not included in CLP04, the PLB segment is used with the recommended HIPAA adjustment reason code of "AH."

Q. For an 837 transaction what do I put in the CLP01 field on the 835?

A. The value in the CLM01 of the 837 is expected in the CLP01 segment of the 835.

Q. How should paper transactions be included in the 835 format?

A. All claims submitted for payment should be reported on the 835 in the 2100 loop.

Q. How should rejections be indicated on the 835?

A. Transactions denied for payment should be reported at claim level in the 835. The reason for rejection should be reported in the LQ segment with the qualifier of RX and the appropriate NCPDP reject code (see www.ncdp.org/main_frame.htm). The qualifier "HE" can be used, when appropriate with the appropriate HIPAA code (see www.wpc-edi.com/codes/Codes.asp). CLP02 should have the value of "04." NCPDP does not recommend the use of MOA and MOI segments for this purpose.

Q. How should repayments be indicated on the 835?

A. Repayments are claim specific adjustments. Therefore, they should be reported in the CAS segment.

Q. How should membership fees be indicated on the 835?

A. Membership fees that occur at claim level must be reported in the CLP segment. Membership fees that occur at the check level must be reported in the PLB segment with agreed upon codes via a trading partner agreement between the payer and provider.

Q. How should cross over claims be entered on the 835?

A. Cross over claims that represent a notification of a transaction forwarded to another party for payment response should be reported in the CLP segment with a claim status code of 23. Crossover payments should be handled as any other payment on the 835.

Q. How should payables be entered on the 835?

A. The Task Group is unable to provide a response to this question without further clarification from the submitter.

Q. How should pass through claims be indicated on the 835?

A. Pass through claims represent claims processed but forwarded to another party for payment. Pass through claims should be reported in the CLP segment with CLP02=27 and CLP04=0.

Q. Should I put interest payments in the PLB segment?

A. If the interest payment is for an individual claim and the value is included in CLP04, the CAS segment is used. If the interest payment value is not included in CLP04, the PLB segment is used with the recommended HIPAA Adjustment Reason code of 51.

Q. How should generic payments be indicated on the 835?

A. If the generic payment is for an individual claim and the value is included in CLP04, the CAS segment is used. If the generic payment value is not included in CLP04, the PLB segment is used with the appropriate HIPAA Adjustment Reason code.

Q. How should generic recoupments be indicated on the 835?

A. If the recoupment is for an individual claim and the value is included in CLP04, the CAS segment is used. If the recoupment value is not included in CLP04, the PLB segment is used with the appropriate HIPAA Adjustment Reason code.

Q. Should late charges go in the PLB segment on the 835?

A. If the charge is for an individual claim and the value is included in CLP04, the CAS segment is used. If the late charge value is not included in CLP04, the PLB segment is used with the HIPAA Adjustment Reason code of L6.

Q. Should capitation fees go in the PLB segment?

A. Capitation charges should be reported in the PLB segment of the 835 with the appropriate HIPAA Adjustment Reason code.

Q. If a processor sends an 835 file on behalf of a plan but does not cut the check, does the 835 need to have the check number in the TRN02 field?

A. NCPDP recommends that if BPR02 is not equal to \$0.00, then the value of BPR01 = "1." BPR04 should be CHK when payment is provided by check regardless of origin of check. TRN02 should be the check number based on this value of BPR04. This allows the proper reassociation of the check to the remittance.

Q. Where is the appropriate place to report the member group number on the X12N 835?

A. If a payer wants to return the member group number we number, we recommend reporting in the 2100 REF Segment "Other Claim Related Identification" using the qualifier 1L in REF01 and the group number in REF02. This number may be the actual number under which the claim was processed or the submitted group number.

Q. Please clarify the appropriate reporting of the prescription refill number in the CLP Segment since it requires two components, the prescription number and the refill number?

A. If the prescription number and other information in the claim will not uniquely identify the service without providing the refill number, the payer may include both in the CLP01 by reporting the prescription number, the characters "FILL" followed by the refill number. Example: CLP01 = 12345FILL3.

Note: Question was submitted to ANSI X12 and was approved for posting in May 2009.