Program Memorandum
Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-03-067 **Date: AUGUST 22, 2003**

CHANGE REQUEST 2839

SUBJECT: National Council for Prescription Drug Programs (NCPDP) Batch Transaction Standard 1.1 Billing Request Companion Document

The purpose of this Program Memorandum (PM) is to provide Durable Medical Equipment Regional Carriers (DMERCs) with a revised companion document. This PM supercedes CR 2713 dated May 23, 2003 which provided you with the first version of the NCPDP Companion Document. The revised companion document is based on the NCPDP protocol document for submitting retail pharmacy drug claims in the Telecommunication Standard Specifications and Implementation Guide (IG) Version 5.1 and Batch Standard 1.1. It clarifies the DMERC expectations regarding data submission, processing, and adjudication. The revised companion document is to be provided to retail pharmacy drug claim submitters (either provider, billing agent, or clearinghouse) that will submit retail pharmacy drug claims to Medicare electronically. The revisions in this companion document were based on recommendations/decisions made by CMS, DMERCs and ViPS. The revisions made to the original companion document sections are as follows:

NCPDP Implementation and Testing - Cost of NCPDP Implementation Guide - corrected
NDC - Updated
General Requirements - Sections 4, 7, 8, 10, 12 updated
Compound Drugs - Value 11-Immunosuppressive Compounds - added, Section 2 updated
End Stage Renal Disease - Updated
Medigap - Updated
Medicaid - Added
MSP - Updated
Partial Fills - Updated
Prior Authorization Segment - Modifiers for Compound Drugs - added, *(This functionality is currently not available. System changes will be needed pending future enhancements. You will be notified in a future CR).*

DMERC Information Form (DIF) term added

In addition, the following fields have been updated, added or removed:

Term "Not Used" - removed from table

Group ID field (301-C1) -updated to accept "XXMEDICAID" when patient has Medicaid coverage and to specify the two position state alpha code. *(This functionality is currently not available. System changes will be needed pending future enhancements. You will be notified in a future CR).*

880-K1 - updated
332-CY - removed
336-8C - removed
405-D5 - updated
498-PF - updated
498-PJ - updated
462-EV - added
301-C1 - updated
429-DT - removed
412-DC - updated
490-UE - updated
880-K7 - updated
339-8C - removed
303-C3 - removed
498-PC - updated
498-PG - updated
307-C7 - added
880-K5 - updated
498-PM - updated
461-EU - removed
447-EC - updated
498-PB - updated
331-CX - removed
524-FO - removed
436-E1 - updated
498-PE - updated
498-PH - updated
461-EU – updated
401-D1 - updated
405-D5 - removed
405-EV - removed
488-RE - updated

Provider Education Business Requirements

Contractors, Intermediaries or Carriers shall inform affected provider communities by posting relevant portions of this instruction on their Web sites within two weeks of the issuance date of this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about "National Council for Prescription Drug Programs (NCPDP) Batch Transaction Standard 1.1 Billing Request Companion Document" is available on your Web site.

NCPDP Companion Document

The revised NCPDP companion document is included as an attachment to this PM.

Attachment

The *effective date* for this PM is August 22, 2003.

The *implementation date* for this PM is September 8, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2004.

If you have any questions, contact Tom Latella, at (410) 786-1310 or e-mail tlatella@cms.hhs.gov.

Attachment

Attachment

Companion Document
To Supplement The
NCPDP VERSION 5.1 BATCH TRANSACTION STANDARD
1.1 BILLING REQUEST
For Exchanges With Medicare Durable Medical Equipment Regional Carriers

NCPDP Implementation and Testing

Each retail pharmacy that transmits retail drug claims electronically must use the NCPDP Batch Standard version 1.1 by October 16, 2003. The NCPDP standard will be accepted for retail pharmacy drug claims only. Claims for supplies and services must be billed using version 4010A1 of the ANSI ASC X12N 837 and must be submitted in a separate transmission from the NCPDP retail drug claims.

A pharmacy that elects to use a clearinghouse for translation services is liable for those costs.

Retail pharmacies, agents, and clearinghouses planning to exchange electronic retail pharmacy drug claims with Medicare must schedule testing with their DMERC by August 1, 2003. There is no Medicare charge for this system testing.

The NCPDP Standards, Implementation Guides and Data Dictionary can be obtained at www.ncpdp.org for a fee of $650.00 or by becoming a member for $550.00.

Note: Non-retail pharmacies are to bill using the X12 837 4010 A1.

National Drug Code (NDC)

Pharmacies are required to transmit the NDC in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. The NDC replaces the HCPCS codes for retail pharmacy drug transactions billed to DMERCs via the NCPDP standard.

Note: DMERCs must accept NDC codes for oral anti-cancer drugs billed using the National Standard Format (NSF), ANSI X12N, NCPDP and paper. All other paper claims are to be billed using HCPCS.

General Requirements:

1. This guide was created to provide DMERC specific requirements when creating an incoming NCPDP file. This document contains DMERC valid values for elements and lists only the segments and elements which apply to a DMERC claim.

2. Suppliers will create the Billing Request transaction as required in the NCPDP standard and as clarified within this document.

3. Only Segments and Fields that are "Mandatory" (M) in the standard, or shown as "Required" (R) or "Situational" (S) in this document should be sent. If a Segment or Field is marked as "Situational", it is only sent if the data condition stated applies. If a field is not shown in this document, or if a data condition is not met, it is not used for Medicare.

4. Medicare will only accept and process Batch Transactions using the NCPDP Batch Standard version 1.1 with the Telecommunication Standard version 5.1. The Batch Standard is a file transmission of one header, one or more detail records, and one trailer. The detail records are built using the Telecommunication Standard version 5.1, with one or more transactions (claims) per transmission (one detail record).
5. Medicare will only accept and process Billing Transactions (value B1 in the Transaction Header Segment, Transaction Code field 103-A3).

6. The following segments are required for Medicare processing:

    - Patient Segment
    - Insurance Segment
    - Prescriber Segment
    - Claim Segment
    - Pricing Segment
    - Clinical Segment

7. Suppliers may submit up to four detail record transactions per detail record transmission except for compound billings. Only one detail record transaction per detail record transmission is allowed when billing for a multi-ingredient prescription.

8. The Prior Authorization Segment, the Coordination of Benefits/Other Payments Segment and the Compound Segment are to be used for Medicare when certain conditions apply.

9. Data elements that are defined by a qualifier must contain valid and appropriate information for that qualifier.

10. Delimiters must be used to distinguish and separate data elements and segments as specified in the NCPDP standard.

11. The transaction must adhere to the data conventions as stated in section 2.5 of the NCPDP Telecommunication Standard Implementation Guide version 5.1.

12. Medicare will only process a format of 9(5)V99 for monetary fields rather than the maximum format of 9(7)V99 as specified in the NCPDP implementation guide. A monetary amount of 9(7)V99 would far exceed Medicare coverage parameters and could be assumed to be an error. Medicare would reject monetary entries larger than 9(5)V99 as they are assumed to be data entry transcription or another manual error. Under HIPAA compliancy rules, plans are permitted to reject transactions that exceed coverage parameters, even if compliant with implementation guide requirements.

Compound Drugs

Compounded drugs will be billed using the Compound Segment in the NCPDP standard. Compounded Prescription guidance includes:

1. The Compound Route of Administration field (452-EH) will be used to distinguish the Nebulizer Drug Compounds from Other Drug Compounds. This field is the route of administration of the complete compound mixture. The valid values Medicare will use in this field are:

   3 - Nebulizer Compounds
   11 - Immunosuppressive Compounds

2. The Compound Ingredient Drug Cost field (449-EE) will equal the Amount Submitted for each claim line.

   Compounds for inhalation drugs should only be used for multiple active ingredients. For single active ingredients, use the Claim segment.

   Additionally, for Nebulizer drugs, suppliers must adhere to the following data requirements in the Compound Segment of the inbound NCPDP claim:

   A. The Compound Ingredient Basis of Cost Determination field (490-UE), should equal “09” (Other) to identify the ingredient that would normally be assigned a KP modifier.

   B. All other drugs in the Compound Segment will be assigned a KQ modifier by Medicare during processing to ensure proper completion of the claim.

Parenteral Nutrition Products

Parenteral nutrition claims must be billed on the X12N 837 using HCPCS codes.

Enteral Nutrition Products

Enteral nutrition claims must be billed on the X12N 837 using HCPCS codes.

End Stage Renal Disease (ESRD)

ESRD drug claims must be billed on the X12N 837 using HCPCS codes.

Epoetin (EPO)

EPO associated with ESRD must be billed on the X12N 837.
Non-ESRD EPO must be billed on the NCPDP.

Home Infusion Products

Claims for home infusion products must be billed on the ASC X12N 837 using the HCPCS codes to identify the drug and related supply. Home infusion pharmacies are professional pharmacies and will not use the NCPDP format for submitting claims to Medicare.

Remittance Advice and X12N 277 Claim Status Response

An X12N 835 or 277 received in response to an NCPDP claim will contain invalid data in the Units field. Medicare currently does not accept a field size of 9(7)v999 for the Metric Decimal Quantity field in the 835 or 277 transaction. When this field is transferred from an NCPDP claim to an X12N 835 or 277 outbound transaction, data in this field will be truncated. This will be corrected in the October, 2003, release of the X12N 835 and 277 flat files.

Medigap

The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage:

1. The Group Id (301-C1) on the insurance segment is not blank.
2. For Coordination of Benefits (COB) related to Medigap, the Patients Medigap Plan Id Number will be submitted in the Alternate Id (330-CW) in the Claim segment.
3. The Medigap Insurer Id (OCNA number) will be submitted in the Group Id (301- C1) in the Insurance segment.

    Note: Medigap takes priority when there is dual Medigap and Medicaid in a claim based situation.

Medicaid

The following field must be submitted in order to allow Medicare to determine that a beneficiary has claim based Medicaid coverage and to specify where the coverage is:

1. The Group Id (301-C1) on the Insurance segment is not blank.
2. The two position state alpha code followed by the word "MEDICAID" must be submitted in the Group Id (301- C1) in the Insurance segment.
   Example: "XXMEDICAID" such as NYMEDICAID or FLMEDICAID

MSP Claims

When Medicare is the secondary payer, (MSP) pharmacies must complete the following fields:

1. The Original Submitted Amount will be sent in the Gross Amount Due (430-DU) on the Pricing Segment;

2. All other amounts reported in 431-DV will be qualified as follows in the Other Payer Amount Paid Qualifier (342-HC):

    The Primary Amount Paid (08) - What the payer actually paid versus what was allowed;
    The Primary Allowed Amount (99) - What the payer actually allowed;

The Obligated to Accept Amount (07) - The amount that the pharmacy has contracted with the original payer, as the amount the pharmacy will accept for payment.

Partial Fills

Medicare does not process the partial and completion billing for prescriptions as described in the NCPDP Telecommunication Standard Implementation Guide. Medicare should be billed the actual dispensing. When submitting partial fill claims to Medicare, pharmacies must submit the Actual Quantity Dispensed in element 442-E7.

Prior Authorization Segment

The NCPDP standard contains a 500-position field in the Prior Authorization Segment (498-PP Prior Authorization Supporting Documentation) that supports one occurrence of narrative information. Retail pharmacies must use this narrative field to submit the following information relating as required for Medicare claims processing:

A) Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF)
B) Narrative Supporting Documentation
C) Facility Name and Address
D) Modifiers for compound drugs

The matrix starting on page 17 of this document provides detailed instruction for formatting these 500 positions when the narrative field is being used to submit any of the information.

NCPDP VERSION 1.1 MEDICARE BILLING REQUEST BATCH TRANSACTIONS

Usage requirements: M=Mandatory in Standard; R=Required for Medicare implementation; S=Situational usage as defined

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Batch Header Record			M	
7∅1	Segment Identification	∅∅	M	
88∅-K6	Transmission Type	T, R, E	M	Medicare only accepts “T” Transaction
88∅-K1	Sender ID (Submitter ID)		M	Enter number assigned by the Medicare contractor
8∅6-5C	Batch Number		M	This number must match the Batch Number (8∅6-5C) in the Batch Trailer
88∅-K2	Creation Date		M	
88∅-K3	Creation Time		M	
7∅2	File Type	P or T	M	Use “T” when submitting a test file Use “P” when submitting a production file
1∅2-A2	Version/Release Number	11	M	
88∅-K7	Receiver Id	∅∅811, ∅∅635, ∅∅885, ∅5655	M	Use the receiver identifier as directed by the Carrier to whom the transaction is sent
Batch Detail Record			M	
7∅1	Segment Identification	G1	M	
88∅-K5	Transaction Reference Number		M	
Transaction Header Segment			M	
1Ø1-A1	BIN Number		M	Assigned BIN number for network routing
1Ø2-A2	Version/Release Number	51	M	
1Ø3-A3	Transaction Code	B1	M	
1Ø4-A4	Processor Control Number		M	Submit the Patient Account Number
1Ø9-A9	Transaction Count	1,2,3,4	M	Carriers will support up to four claims per transmission
2Ø2-B2	Service Provider ID Qualifier	∅4	M	∅4 – Medicare

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
2Ø1-B1	Service Provider ID		M	Enter the supplier ID number assigned by the National Supplier Clearinghouse
4Ø1-D1	Date of Service		M	From Date of Service
11Ø-AK	Software Vendor/Certification ID	Blanks	M	
Patient Segment			R	
111-AM	Segment Identification	Ø1	M	Patient Segment
3∅4-C4	Date of Birth		R	
3∅5-C5	Patient Gender Code	∅, 1,2	R	Use code 1 or 2
3∅7-C7	Patient Location	1, 2, 3, 4, 5, 6, 7, 8, 9, 1∅, 11	R	1=Home 2=Inter-care 3=Nursing Home 4=Long Term/Extended Care 5=Rest Home 6=Boarding Home 7=Skilled Care Facility 8=Sub-acute Care Facility 9=Acute Care Facility 1∅=Outpatient 11=Hospice
31∅-CA	Patient First Name		R	
311-CB	Patient Last Name		R	
322-CM	Patient Street Address		R	
323-CN	Patient City Address		R	
324-CO	Patient State/Province Address		R	
325-CP	Patient ZIP/Postal Zone		R	
Insurance Segment			M	
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		M	Enter Beneficiary HIC number
312-CC	Cardholder First Name		R	Enter Beneficiary first name
313-CD	Cardholder Last Name		R	Enter Beneficiary last name

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
3∅1-C1	Group ID		S	Required when Patient has MEDIGAP coverage (Enter the OCNA number) Or When patient has MEDICAID coverage (Enter the two position state alpha code followed by the word MEDICAID). Example: "XXMEDICAID"
3∅6-C6	Patient Relationship Code	1, 2, 3, 4	R	Medicare can only accept code 1
Prescriber Segment			**R**	
111-AM	Segment Identification	Ø3	M	Prescriber Segment
468-EZ	Prescriber ID Qualifier	∅6	R	∅6 for UPIN number
411-D8	Prescriber ID		R	UPIN number
427-DR	Prescriber Last name		R	
498-PM	Prescriber Phone Number		S	Used when submitting a CMN or DIF
COB/Other Payments Segment			**S**	**Required when other insurance processing is involved**
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	1 – 3	M	Medicare accepts associated fields repeated up to three times
338-5C	Other Payer Coverage Type	∅1,∅2,∅3	M	
339-6C	Other Payer ID Qualifier	99	R	Use 99 for a Medicare-assigned identifier if known. After National Plan ID is mandated, use only ∅1
34∅-7C	Other Payer ID		R	
443-E8	Other Payer Date		R	
341-HB	Other payer amount paid count	1 - 9	R	

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
342-HC	Other Payer Amount Paid Qualifier	∅7,∅8,99	R	∅7 - Drug Benefit to report the OTA (Contract Amount). ∅8 - Sum of All Benefits to report the Primary Paid Amount. 99 - Primary Allowed Amount
431-DV	Other Payer Amount Paid		R	If other payer processed claim, but made no payment, enter zero for paid amount and enter appropriate rejection code
471-5E	Other Payer Reject Count		S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
473-6E	Other Payer Reject Code		S	Use only when a previous payer paid less than the full amount of the charge and provided a rejection code on the remittance
Claim Segment			M	
111-AM	Segment Identification	∅7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	∅1=drug or solution	M	
4Ø2-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	ØØ=used when compound is being submitted ∅3=NDC, used for drugs and solutions	M	
4Ø7-D7	Product/Service ID		M	

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
458-SE	Procedure Modifier Count	1, 2, 3, 4	S	Used only when a procedure modifier code applies. Up to four modifiers can be sent
459-ER	Procedure Modifier Code		S	Used only when a procedure modifier code applies. Up to four modifiers can be sent
442-E7	Quantity Dispensed		R	
4∅6-D6	Compound Code	∅ Not specified 1 No compound 2 Compound	R	
3∅8-C8	Other Coverage Code	∅∅-∅8	S	Used only when other coverage exists
33∅-CW	Alternate Id		S	MEDIGAP Plan Id when the beneficiary has Medigap coverage
6∅∅-28	Unit of Measure	EA, GM, ML	R	
Pricing Segment			**M**	
111-AM	Segment Identification	11	M	Pricing Segment
412-DC	Dispensing Fee Submitted		S	A value in this field will automatically create an E∅59∅ amount and will be subtracted from the submitted fee.
433-DX	Patient Paid Amount Submitted		S	Used only when the beneficiary or someone acting on behalf of the beneficiary made a payment for this service
43∅-DU	Gross Amount Due		R	The total submitted amount for this transaction
Compound Segment			**S**	**Required when submitting a drug with multiple active ingredients**
111-AM	Segment Identification	1Ø	M	Compound Segment
45Ø-EF	Compound Dosage Form Description Code		M	

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
451-EG	Compound Dispensing Unit Form Indicator		M	
452-EH	Compound Route of Administration		M	3 – Inhalation. This code will be used to identify Nebulizer compounds 11 – Oral. This code will be used to identify Immunosuppressive Compounds
447-EC	Compound Ingredient Component (Count)	2 - 25	M	Medicare will accept up to 25 ingredients in one compound mixture
488-RE	Compound Product ID Qualifier	" ", ∅3	M	∅3 – NDC Medicare will only recognize NDC codes
489-TE	Compound Product ID		M	
448-ED	Compound Ingredient Quantity		M	
449-EE	Compound Ingredient Drug Cost		R	This will be used as the submitted amount when Medicare creates the service line for this ingredient
49∅-UE	Compound Ingredient Basis Of Cost Determination	Blank = Not specified ∅1=AWP (Average Wholesale Price) ∅2=Local Wholesaler ∅3=Direct ∅4=EAC (Estimated Acquisition Cost) ∅5=Acquisition ∅6=MAC (Maximum Allowable Cost) ∅7=Usual & Customary ∅9=Other	S	∅9 - Required for Inhalation compounds to identify the ingredient that should receive Medicare's KP modifier

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
Prior Authorization Segment			**S**	**1. Required when sending CMN or DIF information.** **2. Required when Patient Location (3Ø7-C7) is other than home to report Facility Name / Address Information** **3. Required when sending Medicare narrative information** **4. Required when sending modifier information for a compound ingredient**
111-AM	Segment Identification	12	M	Prior Authorization Segment
498-PA	Request Type	1 – 3	M	1 = Any request type not included in 2 or 3 below 2 = Recertification CMNs or DIFs 3 = Revision CMNs or DIFs
498-PB	Request Period Date – Begin		M	CMN or DIF Initial Date when sending CMN or DIF Information Or Date of Service when sending Prior Authorization segment when a CMN or DIF is not included

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
498-PC	Request Period Date-End		M	CMN or DIF Recertification or Revision date when sending CMN information.
498-PD	Basis of Request	PR – Plan Requirement	M	
498-PE	Authorized Representative First Name		S	Use to report first name of representative payee for Medicare payment
498-PF	Authorized Representative Last Name		S	Use to report last name of representative payee for Medicare payment
498-PG	Authorized Representative Street Address		S	Use to report street address of representative payee for Medicare payment
498-PH	Authorized Representative State/Province Address		S	Use to report representative payee zip code information for Medicare payment
498-PJ	Authorized Representative Zip/Postal Zone		S	Use to report representative payee state information for Medicare payment

Field #	NCPDP Field Name	Value	Usage Requirement	Medicare Note
498-PP	Prior Authorization Supporting Documentation Free text		S	Use when sending CMN or DIF information, Facility Name/Address Information, Narrative Information or informational modifiers for compound drugs. Refer to the attached Prior Authorization Segment Supporting Document for further details
Clinical Segment			**R**	
111-AM	Segment Identification	13	M	Clinical Segment
491-VE	Diagnosis Code Count	1-4	R	Medicare will only process up to a maximum of four diagnosis codes
492-WE	Diagnosis Code Qualifier	∅1	R	Code ∅1 specifies ICD9-CM diagnosis codes
424-DO	Diagnosis Code		R	The decimal point specified in the ICD9-CM code listing is required
Batch Trailer Record			M	
7∅1	Segment Identification	99	M	
8∅6-5C	Batch Number		M	This number must match the Batch Number (8∅6-5C) in the Batch Header
751	Record Count		M	
5∅4-F4	Message		M	

Prior Authorization Segment Supporting Documentation Field 498-PP (Medicare Mapping)

R/S: R=Required for Medicare implementation; S=Situational usage as defined

	Element Attributes					
Description	**ID**	**R/S**	**Start**	**Length**	**Values**	**Medicare Note**
498-PP Prior Auth Supporting Doc.			**1**	**5ØØ**		
Authorization Information Qualifier	AN	R	1	3	CMN - Certificate of Medical Necessity CNA - Medicare CMN or DIF and Narrative CFA - Medicare CMN or DIF and Facility Name and Address CNF - Medicare CMN or DIF, Narrative, and Facility Name and Address FAC - Facility Name and Address FAN - Facility Name and Address and Narrative NAR - Narrative for Medicare claim MMN – Modifier and Certificate of Medical Necessity MNA – Modifier and Medicare CMN or DIF and Narrative MFA – Modifier and Medicare CMN or DIF and Facility Name and Address MNF – Modifier and Medicare CMN or DIF, Narrative, and Facility Name and Address MAC – Modifier and Facility Name and Address MAN – Modifier and Facility Name and Address and Narrative MAR – Modifier and Narrative for Medicare claim	CMN - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information CNA - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF and narrative information CFA - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address CNF - Indicates that the Supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address FAC - Indicates that the Supporting documentation that follows is Medicare required Facility Name and address FAN - Indicates that the Supporting documentation that follows is Medicare required Facility Name and Address and narrative information NAR - Indicates that the Supporting documentation that follows is Medicare required Narrative Information MMN - Indicates that the Supporting documentation that follows is Medicare modifier information and CMN or DIF information MNA - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information MFA - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address MNF - Indicates that the Supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address MAC - Indicates that the Supporting documentation that follows is Medicare modifier information and Facility Name and Address MAN - Indicates that the Supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address MAR - Indicates that the Supporting documentation that follows is Medicare modifier information and narrative information

Description	ID	R/S	Start	Length	Values	Comments
Data Elements for Medicare CMN or DIF Form ∅8.∅2 Only						
Form Identifier	AN	R	4	6	∅8.∅2 - Immunosuppressive Drug CMN or DIF	
Ordering Physician First Name	AN	R	1∅	12		
Ordering Physician Address	AN	R	22	3∅		
Ordering Physician City	AN	R	52	2∅		
Ordering Physician State	AN	R	72	2		
Ordering Physician Zip	AN	R	74	15		
Certificate on File Ind	AN	R	89	1	Y or N	This certifies that the supplier has a CMN or DIF on file available for the DMERC to review if necessary
Signature Date	DT	R	9∅	8	CCYYMMDD	Date the supplier signed the CMN or DIF form
Question ∅1A - HCPCS	AN	S	98	11	valid drug HCPCS code	Drug prescribed
Question ∅1B - MG	N∅	S	1∅9	4	∅∅∅1 thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅1A
Question ∅1C - Times Per Day	N∅	S	113	2	∅1 - 99	Frequency of administration of Drug Prescribed in question ∅1A
Question ∅2A - HCPCS	AN	S	115	11	Valid drug HCPCS code spaces are valid	Drug prescribed
Question ∅2B - MG	N∅	S	126	4	∅∅∅∅ thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅2A
Question ∅2C - Times Per Day	N∅	S	13∅	2	∅∅ - 99	Frequency of administration of Drug Prescribed in question ∅2A
Question ∅3A - HCPCS	AN	S	132	11	Valid drug HCPCS code spaces are valid	Drug prescribed
Question ∅3B - MG	N∅	S	143	4	∅∅∅∅ thru 9999	Dosage in Milligrams of the Drug prescribed in question ∅3A
Question ∅3C - Times Per Day	N∅	S	147	2	∅∅ - 99	Frequency of administration of Drug Prescribed in question ∅3A
Question ∅4	AN	S	149	1	Y or N	Has the Patient had an organ transplant that was covered by Medicare?
Question ∅5A	AN	S	15∅	1	1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)

Description	ID	R/S	Start	Length	Values	Comments
Question ∅5B	AN	S	151	1	Spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted?
Question ∅5C	AN	S	152	1	Spaces 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung 6 - Whole organ pancreas, simultaneous with or subsequent to a kidney transplant 7 - Reserved for future use 8 - Reserved for future use 9 - Other	Which organ (s) have been transplanted? (List most recent transplant)
Question 11	DT	S	153	8	CCYYMMDD	Date Patient was discharged from the hospital following this transplant surgery
Question 12	AN	S	161	1	Y or N	Was there a prior transplant failure of this same organ?
Filler	AN	S	162	19		Space for possible expansion of data required for Immunosuppressive CMN or DIF
Data Elements for Medicare Required Narrative Data						
Narrative	AN	S	181	8∅	Free Form Text	
Data Elements for Medicare Required Facility name and Address Data						**Required when Patient Location is not ∅1 – Home**
Facility Name	AN	R	261	27		
Facility Address	AN	R	288	3∅		
Facility City	AN	R	318	2∅		
Facility State	AN	R	338	2		
Facility Zip	AN	R	34∅	15		
Data elements for Modifier	AN	S	355	25	∅1-25	
Filler	AN	S	355	146	26-146	Space for possible expansion of data required for Medicare processing