South Carolina Department of Health and Human Services

Standard Companion Guide

Refers to the NCPDP Post Adjudication v4.2 Implementation Guide

Companion Guide Version Number: 10.0

April 2015

Disclosure Statement

Preface

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

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1. Introduction

This section describes how the NCPDP Post Adjudication (4.2) Implementation Guides (IGs) will be detailed with the use of a table. The table contains a row for each segment that South Carolina Department of Health and Human Services (SCDHHS) has something additional, over and above, the information in the IGs.

In addition to the row for each segment, one or more additional rows are used to describe SCDHHS usage for composite and simple data elements and for any other information. The following table is an example:

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

Field	Field Name	Mandatory or Situational	Source	Format	Size	Start	End	SC DHHS Requirement
6Ø1-Ø4	RECORD TYPE	M	P	A/N	2	1	2	
6Ø1-Ø9	TOTAL RECORD COUNT	M	P	N	10	3	12	
895	TOTAL NET AMOUNT DUE	M	P	D	12	13	24	

Scope

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

This Companion Guides contains two types of data; instructions for electronic communications with SCDHHS (Communications/Connectivity Instructions) and supplemental information for creating transactions for SCDHHS while ensuring compliance with the associated Post Adjudication 4.2 Implementation Guide.

The Transaction Instruction component is included in the CG when SCDHHS wants to clarify the Implementation Guide instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by NCPDP's copyrights and Fair Use statement.

Overview

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

References

The CORE v5010 Master Companion Guide Template has been adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

2. Getting Started

Working with SCDHHS

Should you intend to conduct electronic transactions with South Carolina Medicaid, you must first complete and return a Trading Partner Agreement (TPA) to the South Carolina Medicaid Provider Service Center. The TPA delineates the responsibilities of both the provider and SCDHHS.

Once the South Carolina Medicaid Provider Service Center staff receives your completed TPA, they will contact you to give instructions on how to proceed. Should you intend to create files and send them yourself; the S.C. Medicaid EDI Support Center staff will set up an electronic mailbox for you, assign you a user I.D. and password, and notify you that you may submit a transaction for testing. The testing process evaluates both the format of content of your transaction to ensure it is HIPAA compliant.

If you plan to use a clearinghouse to conduct your transactions, it will not be necessary to set up a mailbox for you, nor for you to test with S.C. Medicaid.

Trading Partner Registration

Providers

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or http://www.scdhhs.gov/resource/hipaa-5010-project-status

Vendors/Clearinghouses

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses can be found on the scdhhs.gov website: http://www.scdhhs.gov/resource/hipaa-5010-project-status

The Trading Partner Agreement Enrollment (TPA) form may be found online at: http://www.scdhhs.gov/resource/hipaa-5010-project-status

Testing with the Payer

Becoming HIPAA compliant will require that most healthcare payers, clearinghouses and providers make significant changes to their existing Electronic Data Interchange (EDI) processes. Process change inevitably includes testing for results validation. This testing can be one of the most time consuming efforts in the development cycle. SC Medicaid expects the following approach will optimize test time and expedite our Trading Partners' transition from test to production status.

The following must be performed for each different transaction type that a Trading Partner is approved to submit to SC Medicaid.

Table 1. Payer Testing Table

Test Step	Description
Test Plan	The SC Medicaid EDI Support Center and the Trading Partner will agree to a predefined set of test data with expected results. The matrix will vary by transaction and Trading Partner. Also, we will develop a plan for test-to production transition that considers volume testing and transaction acceptance ratios.
Security	The SC Medicaid EDI Support Center will verify approved Trading Partners have a valid User ID and password.
Connectivity and Transmission Integrity	SC Medicaid Axiom translator-supported connectivity protocols are outlined in the "Understanding Access to SC Medicaid" section of this manual. This first level of testing is complete when the Trading Partner has successfully sent to and received from SC Medicaid Axiom translator a test file via one of the SC Medicaid Axiom translator-supported connectivity options. The SC Medicaid EDI Support Center suggests the Trading Partner limit transactions to small volume (one percent of estimated daily transactions) for this test phase.
Transaction Validation	The SC Medicaid EDI Support Center will verify that approved Trading Partners are submitting transactions allowed per our enrollment applications.
Data Integrity	Data integrity is determined by Level 4 compliance edits performed by the SC Medicaid Axiom translator. The SC Medicaid EDI Support Center will ask a Trading Partner to first submit low volume files. When these are successfully processed, the SC

	Medicaid EDI Support Center will ask for larger volume files (five percent of estimated daily transactions). The SC Medicaid Axiom translator returns transmission acknowledgement and edit result response transactions from this process. The Trading Partner should correct transactions reported as errors and resubmit them. Data integrity testing is successfully completed when the Trading Partner's data has no compliance errors; i.e., achieves 100% acceptance.
Acknowledgement and Response Transactions	Trading Partners must demonstrate the ability to receive acknowledgement and response transactions. The SC Medicaid Axiom translator expects Trading Partners will also implement balancing or reconciliation processes and report transmission discrepancies to us immediately.
Results Analysis	SC Medicaid EDI Support Center and the Trading Partner will review acknowledgement and response transactions for consistency with the predefined expected results.

The Trading Partner must complete testing for each of the transactions it will implement and shall not be allowed to exchange data with SCDHHS in production mode until testing is satisfactorily passed as determined by SCDHHS. Successful testing means the ability to successfully pass HIPAA compliance checking and to process PHI transmitted by Trading Partner to SCDHHS. SCDHHS will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SCDHHS. Such certification must be at least level 4 as defined by WEDI.

Transition from Test to Production Status

The Trading Partner must complete testing for each of the transactions it will implement and will not be allowed to exchange data with SC Medicaid in production mode until testing is satisfactorily passed. SC Medicaid will accept certification from any third-party testing and certification entity that has been identified by the Workgroup for Electronic Data Interchange, Strategic National Implementation Process (WEDI/SNIP) in lieu of a Trading Partner being tested by SC Medicaid. Such certification must be at least level 4 as defined by WEDI.

When the test results have been satisfied, the Trading Partner's submission status will be changed from test to production. At this time, the Trading Partner can begin to send production transaction data to SC Medicaid.

3. Connectivity with the Payer/ Communications

EDI Gateway

McaidNET is the EDI gateway to SC Medicaid. Effective 03/01/2009, no new modem accounts will be created. Effective 07/01/2009, the modem server will no longer be available. The following are communication packages that will be supported:

- SecureFTP
- WS_FTP Pro v8.0 or higher

McaidNET is defaulted to send uncompressed files.

Note: *McaidNET supports file transfers via secure File Transfer Protocol (FTP). Specifications on these options are included later in this manual.*

SC Medicaid accepts the following ASC X12N Version 5010 (Errata) transactions and NCPDP transactions, required with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

- Dental Claim: ASC X12N 837D 005010X224A2 - Health Care Claim: Dental
- Professional Claim: ASC X12N 837P 005010X222A - Health Care Claim: Professional
- Institutional Claim: ASC X12N 837I 005010X223A2 - Health Care Claim: Institutional
- Health Claim Status: ASC X12N 276/277 005010X212 - Health Care Claim Status Request
- Eligibility for a Health Plan: ASC X12N 270/271 005010X279A1 - Health Care Eligibility Benefit Inquiry
- Premium Payment: ASC X12N 820 005010X218A1
- Enrollment: ASC X12N 834 005010X220A1
- Claim Payment: ASC X12N 835 005010X221A1
- NCPDP Post Adjudication 4.2

The McaidNET platform is available 24 hours a day, seven days a week, with the exception of infrequent maintenance performed on Sundays.

If you have any questions regarding the McaidNET platform, please call the SC Medicaid EDI Support Center toll-free at 1-888-289-0709, Option 1 then Option 1.

Access the Communications Guide online:
http://www1.scdhhs.gov/openpublic/hipaa/webfiles/Communication%20Guide%205010%20OCT2011.pdf

Contact Information

EDI Customer Service/Technical Assistance

The South Carolina Medicaid EDI Support Center can assist you with your questions about HIPAA-related transactions, code sets and related provider training opportunities.

Call 1-888-289-0709 or send Email to EDIG.OPS-MCAID@palmettogba.com

Provider Service Number

The South Carolina Provider Service department can assist you with your questions at 1-888-289-0709 or by submitting an inquiry at Provider Inquiry.

Applicable Websites / Email

Provider Services: http://www.scdhhs.gov/organizations

Contact a Provider Service Representative: http://www.scdhhs.gov/contact-us

To ensure receipt and processing of claims for services, providers are reminded that all hardcopy Medicaid claims and corrected Edit Correction Forms (ECF) must be mailed to:

Medicaid Claims Receipt
Post Office Box 1412
Columbia, South Carolina 29202-1412

Updates to provider information should be mailed to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

Updates and changes will continue to be posted to our website at www.scdhhs.gov as we continue to improve the services that we provide to both Medicaid providers and beneficiaries. Please continue to review your Medicaid Policy manual for additional policy changes and updates.

4. Control Segments / Envelopes

Transaction envelopes (i.e., ISA, IEA, GS and GE segments) should be populated per instructions found in in the South Carolina Communications Manual. Transactions returned by SC Medicaid to the Trading Partner will be enveloped consistent with the specifications described in Example 1B.

5. Payer Specific Business Rules and Limitations

ISA and Case Requirements

1. Trading Partners must envelope (ISA-IEA) different transactions separately.
2. SC Medicaid's compliance edits reject the ISA-IEA content when any transaction within that ISA IEA is not 100% compliant.
3. SC Medicaid's processes will perform a case conversion (to UPPERCASE) on all EDI data.

6. Acknowledgments/Reports

SCDHHS will send an Acknowledgment Medic Report- an HTML summary of the transaction via 999 and 997.

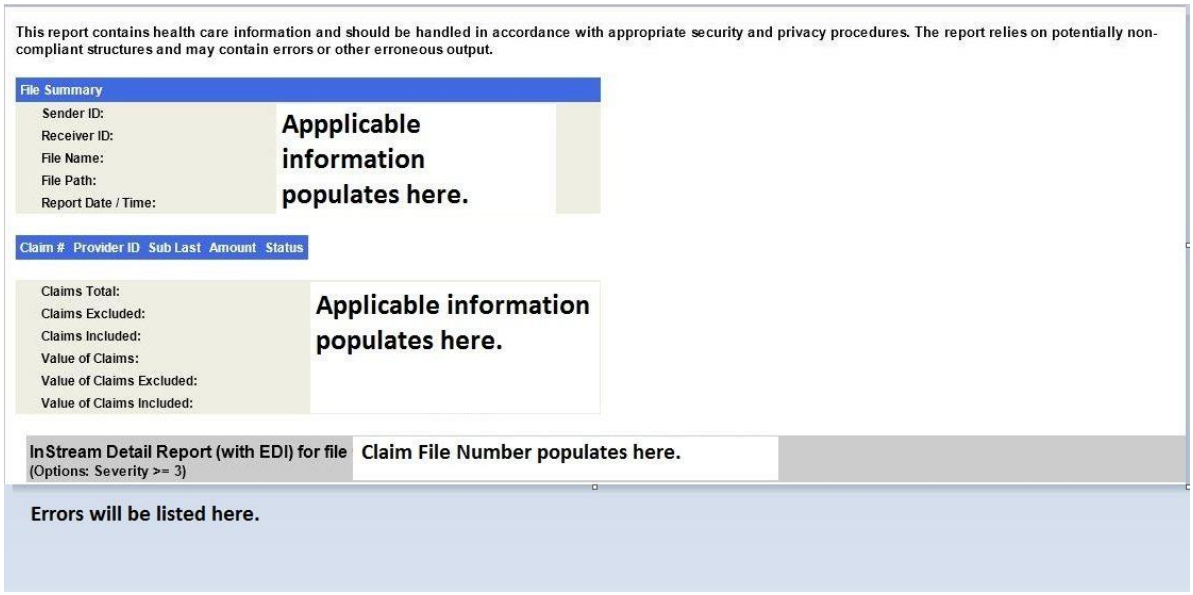

Figure 1. Medic Report Sample

7. Trading Partner Agreements

Trading Partners

An EDI Trading Partner is defined as any SCDHHS customer (provider, billing service, software, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from SCDHHS.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

Providers

Trading Partner Agreement Enrollment Instructions for Providers can be found on the scdhhs.gov website or http://www.scdhhs.gov/resource/hipaa-5010-project-status

Vendors/Clearinghouses

Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses can be found on the scdhhs.gov website: http://www.scdhhs.gov/resource/hipaa-5010-project-status

The Trading Partner Agreement Enrollment (TPA) form may be found online at: http://www.scdhhs.gov/resource/hipaa-5010-project-status

Completion of the S.C. Medicaid Trading Partner Agreement

Page 1

I.A.1., Name: Provider or organization name. The name must match the S.C. Medicaid Provider Number in I.A.2. For instance, if you have an organization name, you must provide a group ID; if you have an individual name, you must provide an individual ID. If you have both an individual and a group ID, you must complete two separate TPAs, one for each ID.

I.A.2., S.C. Medicaid Provider Number: The 6-digit provider ID. If you do not yet have a provider ID, you must contact South Carolina Medicaid Enrollment and apply for one before submitting a TPA to the EDI division. You may contact Enrollment at 803-788-7622, ext: 41650 to request an enrollment packet and to sign up for Electronic Funds Transfer.

I.A.4., Address: The provider's billing or street address.

I.A.5., Contact Name: The provider's enrollment officer, or anyone who can answer questions about the completed TPA.

I.A.6, 7, & 8, Contact Phone, E-mail and Fax: Please complete all information. If we cannot reach you by phone, we will try to contact you via e-mail and fax.

Page 5

Signing for EDI Partner: An original signature is required; stamps, copies, or faxes are not accepted. The signature must be either that of the provider or the providers authorized representative.

Page 6

Provider Name, Medicaid ID#, Address, and Phone: Must all be the same as the information provided on page 1.

NPI #: The National Provider ID for the provider ID listed. Do not leave this blank - we will not process the TPA without the NPI.

Name and Title: Must be the name and title of the person who signs pages 5 and 8.

The Provider will Submit Claim: If you would like a Web Tool ID, indicate the number of user IDs needed. Each person must have their own user ID.

Other Company or Software: If you are using a third party to submit your claims, list the name of your clearinghouse or software vendor. If you have your own S.C. Medicaid Submitter ID, you can list it here.

Page 8
Signature: Must be the same individual who signed page 5 and who was reflected under "Name and Title" section on page 6.

Appendix B
Sharing your NPI: If the TPA is for an individual provider, please complete the Individual Provider section only. If the TPA is for a group ID, complete the Group section only. It is very important that the NPI that you provide is for the provider ID listed.
Note: *The TPA will not be processed without the NPI information. Information for obtaining and NPI number is located on page 1 of the TPA.*

Additional Information:

- **Trading Partner Agreement Enrollment Instructions for Providers**
- **Trading Partner Agreement Enrollment Instructions for Vendors and Clearinghouses**

Trading Partner Agreement 01/01/2013

8. Transaction Specific Information

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

Table 2. NCPDP Post Adjudication Healthcare Claim Professional Table

8.1 POST ADJUDICATION HISTORY HEADER RECORD										
Field	**Field Name**	**Description**	**Values**	**Mandatory or Situational**	**Source**	**Format**	**Size**	**Start**	**End**	**SCDHHS Requirement**
601-04	RECORD TYPE	Type of record being submitted.	CD- *Post Adjudication History Compound Detail Record1* CE- *Post Adjudication History Compound Detail Record2* DE- *Post Adjudication History Detail Record* PA- *Post Adjudication History Header Record* PT- *Post Adjudication History Trailer Record*	M	P	A/N	2	1	2	
102-A2	VERSION/RELEASE NUMBER	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	10- Version 1.0 20- Version 2.0 21- Version 2.1 22- Version 2.2 23- Version 2.3 30- Version 3.0 31- Version 3.1 40- Version 4.0 41- Version 4.1 4.2- Version 4.2	M	P	A/N	2	3	4	SCDHHS uses 4.2- "42"
879	SENDING ENTITY IDENTIFIER	Party creating the data enclosed or the entity for whom the data is being enclosed.	n/a	M	P	A/N	24	5	28	NO ENTRY IS NEEDED. SCDHHS will populate this field with the SC assigned PROVIDER NUMBER (MCO ID) via the system translator.
806-5C	BATCH NUMBER	This number is assigned by the processor/sender. A number generated by the sender to uniquely identify this	n/a	M	P	N	7	29	35	

		batch from others, especially when multiple batches may be sent in one day.								
880-K2	CREATION DATE	Date the file was created.	n/a	M	P	N	8	36	43	Format CCYYMMDD
880-K3	CREATION TIME	Time file was created.	n/a	M	P	N	4	44	47	Format HHMM
880-K7	RECEIVER ID	An identification number of the endpoint receiver of the data file.	n/a	M	P	A/N	24	48	71	
601-06	REPORTING PERIOD START DATE	The first day of the period being reported in the file.	n/a	M	P	N	8	72	79	Format CCYYMMDD
601-05	REPORTING PERIOD END DATE	The last day of the period being reported in the file.	n/a	M	P	N	8	80	87	Format CCYYMMDD
702-MC	FILE TYPE	Code identifying whether the file contained is test or production data.	T- Test- In processing systems, the test environment P- Production- In processing systems, the live environment	M	P	A/N	1	88	88	
981-JV	TRANSMISSION ACTION	Indicates whether this is a replacement file, file updates or a file delete	F- Full Replace D- Delete - Remove existing file U- Update - Modify an existing file O- Original Submission (New)- a new file C- Correction/Adjustment to previous batch- Modify a previously submitted batch D- Deletion of previous batch- Removal of a previously submitted batch P- Replacement of a previous batch (delete followed by add)- The removal of an existing batch previously submitted with the addition of the submitted batch immediately following.	M	P	A/N	1	89	89	Please use value “O”
888	SUBMISSION NUMBER	Indicates the number of times a data set has been resent.	Blank- Not Specified 00- First Submission 01- First Resubmission 02- Second Resubmission 03-99 Number of Resubmission	M	P	A/N	2	9Ø	91	

	FILLER	n/a	n/a	M	P	A/N	3609	92	3700	

8.2 POST ADJUDICATION HISTORY DETAIL RECORD

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	SCDHHS Requirement
601-04	RECORD TYPE	Type of record being submitted.	CD- *Post Adjudication History Compound Detail Record1* CE- *Post Adjudication History Compound Detail Record2* DE- *Post Adjudication History Detail Record* PA- *Post Adjudication History Header Record* PT- *Post Adjudication History Trailer Record*	M	P	A/N	2	1	2	
398	RECORD INDICATOR	Action to be taken on the record.	Blank- Not Specified 0- New Record 1- Overwrite existing record 2- Delete existing record	S	P	A/N	1	3	3	SCHDDS uses values 0, 1, or 2.
SECTION DENOTES ELIGIBILITY CATEGORY:										
248	ELIGIBLE COVERAGE CODE	Coverage Level Code. Code indicating the level of coverage being provided for the insured.	CHD- Children Only DEP- Dependents Only E1D- Employee and One Dependent E2D- Employee and Two Dependents E3D- Employee and Three Dependents E5D- Employee and One or More Dependents E6D- Employee and Two or More Dependents E7D- Employee and Three or More Dependents E8D- Employee and Four or More Dependents E9D- Employee and Five or More Dependents ECH- Employee and Children EMP- Employee Only ESP- Employee and Spouse FAM- Family IND- Individual SPC- Spouse and Children SPO- Spouse Only TWO- Coverage for only two people	S	P	A/N	3	4	6	

898	USER BENEFIT ID	Member's benefit ID based upon User Group Number from Eligibility when submitted by Client.	n/a	S	P	A/N	10	7	16	
899	USER COVERAGE ID	Member's coverage ID based upon User Group Number submitted by Client on eligibility data.	n/a	S	P	A/N	10	17	26	
246	ELIGIBILITY GROUP ID	Identifier of the group that determines eligibility parameters for the member when submitted by the client.	n/a	S	P	A/N	15	27	41	
270	LINE OF BUSINESS CODE	Line of Business Code from Client eligibility or as defined by trading partner agreement.	n/a	S	P	A/N	6	42	47	
267	INSURANCE CODE	Special group/member data as supplied on eligibility record when supplied by the client.	n/a	S	P	A/N	20	48	67	
220	CLIENT ASSIGNED LOCATION CODE	The location of the member within the Client's Company from Client eligibility when submitted by the client.	n/a	S	P	A/N	20	68	87	
222	CLIENT PASS THROUGH	Information from Client eligibility when submitted by the client.	n/a	S	P	A/N	200	88	287	
SUBSECTION DENOTES CARDHOLDER INFORMATION:										
302-C2	CARDHOLDER ID	Insurance ID assigned to the cardholder or identification number used by the plan.	n/a	M	C/P	A/N	20	288	307	1. The number that the submitter transmits in this position is

										echoed back to the submitter in the 835 and other transactions. This field is mapped to bytes 28-42 of the flat file fed into MMIS. It can only be 15 bytes because that's all we allow in MMIS for this field. The NCPDP allows for 20 bytes in field 302-C2. If you put more than 15 bytes in field 302-C2 of the NCPDP, the translator will truncate and only move the first 15 bytes into the MMIS field. SCDHHS does not use this field. Its sole purpose is to tie the encounter back to something in the MCO's system.
716-SY	LAST NAME	Last name.	n/a	S	P	A/N	35	308	342	

717-SX	FIRST NAME	First name.	n/a	S	P	A/N	35	343	377	
718	MIDDLE INITIAL	Middle initial.	n/a	S	P	A/N	1	378	378	
280	NAME SUFFIX	Individual name suffix.	n/a	S	P	A/N	10	379	388	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	40	389	428	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	40	429	468	
728	CITY	Free-form text for city name.	n/a	S	P	A/N	30	469	498	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	South Carolina- 42 See Appendix C- State/Province Address for other state codes.	S	P	A/N	2	499	500	42- South Carolina
730	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.	n/a	S	P	A/N	15	501	515	
B36-1W	ENTITY COUNTRY CODE	Code of the country.	n/a	S	P	A/N	2	516	517	Do not send. SC will not process this information.
214	CARDHOLDER DATE OF BIRTH	Date of Birth of Member.	n/a	S	P	N	8	518	525	
721-MD	GENDER CODE	Code identifying the gender of the individual.	Blank- Unknown 1- Male 2- Female	S	P	N	1	526	526	
274	MEDICARE PLAN CODE	This represents if the member is eligible for Medicare coverage as provided in eligibility data.	Blank- Not specified A- Medicare Part A - Part of the Original Medicare Plan managed by the federal government. Covers some, but not all, of the expenses incurred for inpatient hospital care or medical care that a person may receive at a skilled nursing facility (not a custodial care facility). Some hospice care and some home health care are also covered. Limitations apply, and have deductibles, copays, or other costs to satisfy. B- Medicare Part B - Part of the Original Medicare Plan managed by the federal government. This covers medically necessary services from doctors or	S	P	A/N	1	527	527	

			outpatient hospital care. It also helps with costs associated with some physical and occupational therapist services and some home health care services. A person typically must sign up for Part B and pay a monthly premium in order to benefit from coverage. C- Medicare Part C - Part of Medicare includes medical and other benefits provided through private health benefits companies (approved by the federal government) known as Medicare Advantage Plans. Plans cover the same or better benefits as the Original Medicare Plan with easy-to-budget copay and coinsurance amounts when a person uses a network doctor and hospital. D- Medicare Part D - The optional Medicare prescription drug coverage. X- Medicare Part Unknown - Person is eligible for a Medicare plan but the plan is unidentified Z- Not Medicare Eligible - Person is not eligible for any Medicare plan.							
288	PAYROLL CLASS	A field defined by the client indicating the payroll class of the member.	Blank- Not Specified 1- Hourly 2- Salary	S	P	A/N	1	528	528	
SUBSECTION DENOTES PATIENT INFORMATION:										
331-CX	PATIENT ID QUALIFIER	Code qualifying the 'Patient ID' (332-CY).	Blank -Not Specified Ø1- Social Security Number – Code indicating that the information to follow is the 9-digit number assigned to an individual by the Social Security Administration for various purposes, including paying and reporting taxes. 1J- *Facility ID Number* - ID number assigned by the LTC Facility to the patient Ø2- *Driver's License Number* – Indicator defining the information to follow as the patient's license to operate a motor vehicle Ø3- *U.S. Military ID* – An identification number given to an active or retired member of the US Armed Services or their dependents. Ø4- *Non-SSN-based patient identifier assigned by health plan* – An identification number given to a	S	P	A/N	2	529	530	"06"

332-CY	PATIENT ID	ID assigned to the patient.	member by the health plan that is not based on the member's SSN. Ø5- *SSN-based patient identifier assigned by health plan* – An identification number given to a member by the health plan that is based on the member's SSN with modifications so the number is not equal to the SSN. Ø6- *Medicaid ID* - A number assigned by a state Medicaid agency Ø7- *State Issued ID* - An ID issued by a state for the purpose of identifying the individual for legal requirements. Ø8- *Passport ID* - A document number found within an official identification document that is supplied to an individual by a national government. Ø9- *Medicare HIC#* - The identification of person assigned by Medicare. 1Ø- *Employer Assigned ID* - The identification of a person assigned by the employer. 11- *Payer/PBM Assigned ID* - The identification of a person assigned by the payer or pharmacy benefit manager. 12- *Alien Number (Government Permanent Residence Number)* - The ID number assigned by the government for the individual in the country as a permanent resident. 13- *Government Student VISA Number* – The ID number assigned by the government for the individual in the country on a student VISA. 14- *Indian Tribal ID* - An ID assigned by an Indian Tribal Authority to identify an individual. 99- *Other* - Different from those implied or specified. n/a	S	P	A/N	20	531	550	1. RECIPIENT MEDICAID NUMBER**.** It should only be 10 bytes and is mapped to bytes 18-27 of the flat file. The 332-CY field in the NCPDP allows for 20 bytes but there are

										no Medicaid ID numbers more than 10 bytes.
716-SY	LAST NAME	Last name.	n/a	S	P	A/N	35	551	585	
717-SX	FIRST NAME	First name.	n/a	S	P	A/N	35	586	620	
718	MIDDLE INITIAL	Middle initial.	n/a	S	P	A/N	1	621	621	
280	NAME SUFFIX	Individual name suffix.	n/a	S	P	A/N	10	622	631	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	40	632	671	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	40	672	711	
728	CITY	Free-form text for city name.	n/a	S	P	A/N	30	712	741	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	South Carolina- 42 See Appendix C- State/Province Address for other state codes.	S	P	A/N	2	742	743	42-South Carolina
730	ZIP/POSTAL CODE	Code defining international postal code excluding punctuation.	n/a	S	P	A/N	15	744	758	
A43-1K	PATIENT COUNTRY CODE	Code of the country.	n/a	S	P	A/N	2	759	760	Do not send. SC will not process this information.
304-C4	DATE OF BIRTH	Date of Birth of Member.	n/a	S	P	N	8	761	768	
305-C5	PATIENT GENDER CODE	Code identifying the gender of the patient.	Blank- Unknown 1- Male 2- Female	S	P	N	1	769	769	
247	ELIGIBILITY/PATIENT RELATIONSHIP CODE	Individual Relationship Code. Code indicating the relationship	Ø- Not Applicable 1- Spouse 2- Son or Daughter 3- Father or Mother	S	P	N	2	770	771	

		between two individuals or entities.	4- Grandfather or Grandmother 5- Grandson or Granddaughter 6- Uncle or Aunt 7- Nephew or Niece 8- Cousin 9- Adopted Child 1Ø- Foster Child 11- Son-in-law or Daughter-in-law 12- Brother-in-law or Sister-in-law 13- Mother-in-law or Father-in-law 14- Brother or Sister 15- Ward 16- Stepparent 17- Stepson or Stepdaughter 18- Self 19- Child - Dependent between the ages of Ø and 19; age qualifications may vary depending on policy 2Ø- Employee 21- Unknown 22- Handicapped Dependent 23- Sponsored Dependent - Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy 24- Dependent of a Minor Dependent 25- Ex-spouse 26- Guardian 27- Student - Dependent between the ages of 19 and 25 attending school; age qualifications may vary depending on policy 28- Friend 29- Significant Other 3Ø- Both Parents - The residence or legal custody of the student is with both parents 31- Court Appointed Guardian 32- Mother 33- Father 34- Other Adult 36- Emancipated Minor - A person who has been judged by a court of competent jurisdiction to be allowed to act in his or her own interest; no adult is legally responsible for this minor; this may be declared as a result of marriage 37- Agency Representative 38- Collateral Dependent - Relative related by blood or marriage who resides in the home and is dependent							

			on the insured for a major portion of their support 39- Organ Donor - Individual receiving medical service in order to donate organs for a transplant 4Ø- Cadaver Donor - Deceased individual donating body to be used for research or transplants 41- Injured Plaintiff 43- Child Where Insured Has No Financial Responsibility - Child is covered by the insured but the insured is not the legal guardian 45- Widow 46- Widower 47- State Fund - The state affiliated insurance organization providing coverage and or benefits to the claimant 48- Stepfather 49- Stepmother 5Ø- Foster Parent 51- Emergency Contact 52- Employer 53- Life Partner 55- Adopted Daughter 56- Adopted Son 57- Adoptive Father 58- Adoptive Mother 59- Adoptive Parents 6Ø- Annuitant 61- Aunt 62- Brother 63- Brother-in-law 64- Business 65- Business Associate 66- Business Insurance Trust 67- Business Partner 68- Charity 7Ø- Children of Marriage 71- Company 72- Corporation 73- Creditor 74- Daughter 75- Daughter-in-Law 76- Dependent 78- Estate 79- Ex-wife 8Ø- Family Member 81- Father-in-Law						

			82- Fiancé (Male) 83- Finance (Female) 84- Fiduciary 86- Foster Daughter 87- Foster Father 88- Foster Mother 9Ø- Foster Son 91- God Daughter 92- God Father 93- God Parents 94- God Son 95- Grandchildren 96- Granddaughter 97- Grandfather 98- Grandmother 99- Grandparents A1- Grandson A2- Great Aunt A3- Ex-husband A4- Half Brother A5- Half Sister A6- Husband A7- Institution A8- Mortgage Holder A9- Mother-in-Law B1- Nephew B2- Niece B3- Parents-in-Law B4- Partnership B5- Partner B6- Personal Insurance Trust B7- Sister B8- Sister-in-Law B9- Sole Proprietorship C1- Son C2- Son-in-Law C3- Step Brother C4- Step Children C5- Step Daughter C8- Step Sister C9- Step Son D1- Trust D2- Trustee D3- Uncle D4- Wife							

			D5- Teacher D6- School Counselor D7- School Principal D8- Other School Administrator D9- Coach E1- Activity Sponsor E2- Supervisor E3- Co-worker E4- Minister or Priest E5- Ecclesiastical or Religious Leader E6- God Mother E7- Probation Officer E8- Accountant E9- Advisor F1 -Alma Mater F2 -Applicant F3- Banker F6- Clergyman F7- Client F8 -Club or Organization Officer F9- Doctor G2- Educator/Teacher/Instructor G3- Betrothed G4- Insured G5- Lawyer G6- Medical Care Provider G7- Neighbor G8- Other Relationship G9- Other Relative H1- Owner H4- Payer N1- None OT- Non-applicable Individual Relationship Category ZZ- Mutually Defined							
208	AGE	Calculated from Date of Birth (3Ø4-C4).	n/a	S	P	N	3	772	774	Calculated from Date of Birth (3Ø4-C4).
303-C3	PERSON CODE	Code assigned to a specific person within a family.	n/a	S	P	A/N	3	775	777	
306-C6	PATIENT RELATIONSHIP CODE	Code indicating relationship of patient to cardholder.	Ø- Not Specified 1- Cardholder - The individual that is enrolled in and receives benefits from a health plan 2- Spouse - Patient is the husband/wife/partner of the	S	C	N	1	778	778	

			cardholder 3- Child - Patient is a child of the cardholder 4- Other - Relationship to cardholder is not precise							
309-C9	ELIGIBILITY CLARIFICATION CODE	Code indicating that the pharmacy is clarifying eligibility for a patient.	Ø- Not Specified 1- No Override – Eligibility denial cannot be superseded 2- Override – Eligibility denial is being superseded 3- Full Time Student – A dependent child enrolled as a full time student at a school 4- Disabled Dependent – A dependent, regardless of age, whoever is disabled 5- Dependent Parent - A dependent who is the parent. 6- Significant Other – Partner other than the spouse	S	C	A/N	1	779	779	
336-8C	FACILITY ID	ID assigned to the patient's clinic/host party.	n/a	S	P	A/N	10	780	789	
SECTION DENOTES BENEFIT CATEGORY:										
301-C1	GROUP ID	ID assigned to the cardholder group or employer group.	n/a	M	P	A/N	15	790	804	SCDHHS does not use this data element.
215	CARRIER NUMBER	Account Number assigned during installation.	n/a	S	P	A/N	9	805	813	
757-U6	BENEFIT ID	Assigned by processor to identify a set of parameters, benefits, or coverage criteria used to adjudicate a claim.	n/a	S	P	A/N	15	814	828	
240	CONTRACT NUMBER	Account Number assigned during installation for segments of business	n/a	S	P	A/N	8	829	836	
212	BENEFIT TYPE	Indicates the type of acceptable claims for the group based on the Benefit setup.	Blank- Not Specified 1- *Mail Order Only* - Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service. 2- *Mail Order Member Paper Only* – Claims accepted for payment only when dispensed by pharmacies that primarily conduct their business by delivering the filled prescriptions by mail or parcel service and only	S	P	A/N	1	837	837	

			when the claim is submitted by the member via a request for reimbursement. 3- *Card Only* - Claims accepted for payment only when the prescription is dispensed at retail pharmacies. 4- *Member Paper Only* – Claims accepted for payment when the claim is submitted by the member requesting reimbursement. 5- *Standard Program (Integrated Card, Mail Service & Member Paper Programs*) – Claims accepted from all types of dispensing providers and paper claims submitted requesting reimbursement after dispensing. 6- *Card and member paper only* - Claims accepted for payment only when the prescription is dispensed at a retail pharmacy, or when a paper claim is submitted by the member requesting reimbursement 7- *Mail and Card Only* - Claims accepted for payment only when dispensed by mail service or retail pharmacies; claims submitted by the member requesting reimbursement are not covered. 8- *Discount Card Program* – Claims accepted but members are required to pay 1ØØ% copay for all types of pharmacy claims.							
279	MEMBER SUBMITTED CLAIM PROGRAM CODE	A one-position field indicating the type of member submitted claim program used to process this claim.	Blank-Not Specified 1- *Paper Claim Direct* - Patient has submitted a paper claim for reimbursement after the pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction. The patient pays 100%. 2- *Paperless Claim Direct* – The pharmacy transmits the claim through an NCPDP Telecommunication claim billing transaction and the patient pays 100%. The patient does not need to send in a paper claim as the billing transaction will trigger the reimbursement to the member after a defined period of time. 3- *Paper Submit Only* – Patient must submit a paper claim as there is no Point of Sale (POS) component. 4- *Paper Claim Direct With Dual Pricing* - Same as #1 but reimbursement to a patient may differ if no billing transaction (POS claim) was transmitted. 5- *Paperless Claim Direct With Dual Pricing* – Same as # 2 but reimbursement to the patient may differ if paper claim is received. 6- *Paperless Claim Direct With Mail Pricing*	S	P	A/N	1	838	838	

			7- *Paperless Claim Direct and Paper Submit* 8- *Paper Claim Direct W/ Dual Pricing Determined by Days' Supply*							
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- *Bypass all system edits*. Pays claims at full amount billed with no copay. I- *Bypasses all system edits*. Pays claims at full amount billed with copay applied. J- *Bypasses all system edits*. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.	S	P	A/N	1	839	839	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- *Bypass all system edits*. Pays claims at full amount billed with no copay. I- *Bypasses all system edits*. Pays claims at full amount billed with copay applied. J- *Bypasses all system edits*. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.	S	P	A/N	1	840	840	
282	NON-POS CLAIM OVERRIDE CODE	Used for bypassing system edits for non-Point of Sale (POS) claims and/or modifying pricing logic.	Blank-Not Specified H- *Bypass all system edits*. Pays claims at full amount billed with no copay. I- *Bypasses all system edits*. Pays claims at full amount billed with copay applied. J- *Bypasses all system edits*. Pays claims according to plan pricing and copay specifications. K- Pays claims at full amount submitted with copay applied.	S	P	A/N	1	841	841	
241	COPAY MODIFIER ID	Unique drug list ID that is coordinated for use with the clients copay set-up. Processor defined codes.	n/a	S	P	A/N	10	842	851	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B	S	P	A/N	1	852	852	

			C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity							
293	PREFERRED ALTERNATIVE FILE ID	Indicates the preferred alternative file ID number used to determine processing.	n/a	S	P	A/N	10	853	862	
308-C8	OTHER COVERAGE CODE	Code indicating whether or not the patient has other insurance coverage.	Ø-Not Specified by patient 1- *No other coverage* - Code used in coordination of benefits transactions to convey that no other coverage is available. 2- *Other coverage exists-payment collected* - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received. 3- *Other Coverage Billed – claim not covered* - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment denied because the service is not covered. 4- *Other coverage exists-payment not collected* - Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received. 8- *Claim is billing for patient financial responsibility only* - Copay is a form of cost sharing that holds the patient responsible for a fixed dollar amount for each product/service received and regardless of the patient's current benefit status, product selection or network selection.	S	C	N	2	863	864	
291	PLAN BENEFIT CODE	Determines the method by which Insulin and OTC claims are paid. Defined by processor.	n/a	S	P	A/N	2	865	866	
601-01	PLAN TYPE	Identifies the type of plan.	1920- MEDICAID - A program, financed jointly by the federal government and the states, that provides health	S	P	A/N	4	867	870	"1920" - Medicaid

			coverage for mostly low-income women and children as well as nursing-home care for low-income elderly.							
SECTION DENOTES PHARMACY CATEGORY:										
202-B2	SERVICE PROVIDER ID QUALIFIER	Code qualifying the 'Service Provider ID' (2Ø1-B1).	01- *National Provider Identifier (NPI)* - A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS). 05- *Medicaid*- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.	M	C	A/N	2	871	872	South Carolina uses Qualifier 01 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, 05 - Medicaid ID.
201-B1	SERVICE PROVIDER ID	ID assigned to a pharmacy or provider.	n/a	M	C	A/N	15	873	887	This is to whom the payment was made. This is usually the SERVICE PROVIDER (PHARMACY) NPI.
202-B2	SERVICE PROVIDER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Service Provider ID' (2Ø1-B1).	01- *National Provider Identifier (NPI)* - A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS).	S	P	A/N	2	888	889	South Carolina uses Qualifier 01 – National Provider Identifier (NPI).

			05- *Medicaid*- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.							For Atypical Providers, please submit the Qualifier value, 05 - Medicaid ID.
201-B1	SERVICE PROVIDER ID (ALTERNATE)	ID assigned to a pharmacy or provider.	n/a	S	P	A/N	15	890	904	
886	SERVICE PROVIDER CHAIN CODE	Processor specific ID assigned to a chain by processor.	n/a	S	P	A/N	7	905	911	
833-5P	PHARMACY NAME	Pharmacy name.	n/a	S	P	A/N	70	912	981	
726-SR	ADDRESS LINE 1	First line of address information.	n/a	S	P	A/N	40	982	1021	
727-SS	ADDRESS LINE 2	Second line of address information.	n/a	S	P	A/N	40	1022	1061	
728	CITY	Free-form text for city name.	n/a	S	P	A/N	30	1062	1091	
729-TA	STATE/PROVINCE ADDRESS	The State/Province Code of the address.	South Carolina- 42 See Appendix C- State/Province Address for other state codes.	S	P	A/N	2	1092	1093	
730	ZIP/POSTAL CODE	Code defining international postal	n/a	S	P	A/N	15	1094	1108	

		code excluding punctuation.								
887	SERVICE PROVIDER COUNTRY CODE	Indicates the county of the pharmacy	n/a	S	P	A/N	3	1109	1111	Do not send. SC will not process this information.
A93	SERVICE PROVIDER COUNTRY CODE	Indicates the country code of the provider	n/a	S	P	A/N	2	1112	1113	Do not send. SC will not process this information.
732	TELEPHONE NUMBER	Telephone Number	n/a	S	P	N	10	1114	1123	
B10-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number.	n/a	S	P	N	8	1124	1131	
146	PHARMACY DISPENSER TYPE QUALIFIER	Code qualifying the 'Pharmacy Dispenser Type' (29Ø).	Blank- Not Used 1- *Processor-defined* - The processor supports and maintains their own codes. 2- *Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only)* - The values are from the NCPDP Pharmacy Database. 3- Other	S	P	A/N	1	1132	1132	
290	PHARMACY DISPENSER TYPE	Type of pharmacy dispensing product.	n/a	S	P	A/N	2	1133	1134	
150	PHARMACY CLASS CODE QUALIFIER	Code qualifying the 'Pharmacy Class Code' (289).	Blank- Not Used 1- *Processor-defined* - The processor supports and maintains their own codes. 2- *Pharmacy Dispenser Type from NCPDP Pharmacy Database (licensees only)* - The values are from the NCPDP Pharmacy Database. 3- Other	S	P	A/N	1	1135	1135	
289	PHARMACY CLASS CODE	Indicates class of the pharmacy.	n/a	S	P	A/N	1	1136	1136	
266	IN NETWORK INDICATOR	Indicates if the pharmacy dispensing the prescription is considered in network.	Blank- Not Specified *Y- In Network* – The dispensing pharmacy was under contract with the plan to provide services *N- Out of Network* – The dispensing pharmacy was not under contract with the plan	S	P	A/N	1	1137	1137	
545-2F	NETWORK REIMBURSEMENT ID	Field defined by the processor. It identifies the network, for the covered member, used to calculate the	n/a	S	P	A/N	10	1138	1147	

		reimbursement to the pharmacy.								
SECTION DENOTES PRESCRIBER CATEGORY:										
466-EZ	PRESCRIBER ID QUALIFIER	Code qualifying the 'Prescriber ID' (411-DB).	01- *National Provider Identifier (NPI)* - A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS). 05- *Medicaid*- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.	S	C	A/N	2	1148	1149	South Carolina uses Qualifier 01 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, 05 - Medicaid ID.
411-DB	PRESCRIBER ID	ID assigned to the prescriber.	n/a	S	C	A/N	15	1150	1164	This is the prescribing physician's NPI.
466-EZ	PRESCRIBER ID QUALIFIER (ALTERNATE)	Code qualifying the 'Prescriber ID' (411-DB).	01- *National Provider Identifier (NPI)* - A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS). 05- *Medicaid*- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of	S	P	A/N	2	1165	1166	South Carolina uses Qualifier 01 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, 05 - Medicaid ID.

			low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals. The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.							
411-DB	PRESCRIBER ID (ALTERNATE)	ID assigned to the prescriber.	n/a	S	P	A/N	15	1167	1181	This is the prescribing physician's NPI.
296	PRESCRIBER TAXONOMY	The taxonomy is defined as a classification scheme that codifies provider type and provider area of specialization.	The values can be obtained from the following link: http://www.wpc-edi.com/codes/taxonomy	S	P	A/N	10	1182	1191	
295	PRESCRIBER CERTIFICATION STATUS	Indicates a provider's certification in the health plan program.	Blank- Not Specified 1- *Active* – Prescriber has been certified as a participant 2- *Retired (Inactive)* – Prescriber that is no longer working. 3- *Voluntary Inactive* – Prescriber that has given up their certification 4- *Deceased* – Prescriber that has died 5- *Pending health plan approval* – Prescriber has applied for certification and is awaiting finalization of approval process 6- *License Revoked* – Prescriber has had his license taken away 7- *Utilization Review Sanctioned* – Prescriber has been sanctioned due to prescribing habits 8- *Fraud Conviction (Inactive)* – Prescriber has been convicted by the courts of fraud	S	P	A/N	2	1192	1193	

			9- *Administration Action (Inactive)* – Prescriber's license has been deactivated for administrative purposes 1Ø- *Terminated* – Prescriber's certification/license has been terminated 11- *Decertified* – Prescriber's certification has been removed 12- *Reopened after Sanction or Decertification* – Prescriber's certification process is reopened for review after having been revoked 13- *Federal Sanction* – Provider has been restricted by a federal certifying entity. 14- *Out of Network: Participating* 15- *Out of Network: Non-Participating* 16- *In Network: Participating* – prescriber is a contracted plan physician 17- *In Network: Non-Participating* – prescriber is not a contracted plan physician							
716-SY	LAST NAME	Last name	n/a	S	P	A/N	35	1194	1228	
717-SX	FIRST NAME	First name	n/a	S	P	A/N	35	1229	1263	
732	TELEPHONE NUMBER	Telephone Number	n/a	S	P	N	10	1264	1273	
B10-8A	TELEPHONE NUMBER EXTENSION	Extension of the telephone number	n/a	S	C/P	N	8	1274	1281	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	Code qualifying the 'Primary Care Provider ID' (421-DL)	01- National *Provider Identifier (NPI)* – A standard unique health identifier for health care providers. The NPI is a 1Ø position numeric identifier with a check digit in the 1Øth position and is assigned by the National Provider System (NPS). 05- *Medicaid*- A number assigned to a provider by a state Medicaid agency. Each state has a unique identifier. Medicaid is a program established pursuant to Title XIX of the Social Security Act to provide medical benefits for certain categories of low-income individuals. The program provides benefits to indigent and disabled individuals and members of families receiving Aid to Families with Dependent Children. States have the option to provide benefits to a broader range of individuals.	S	C/P	A/N	2	1282	1283	South Carolina uses Qualifier 01 – National Provider Identifier (NPI). For Atypical Providers, please submit the Qualifier value, 05 – Medicaid ID.

			The program is a cooperative arrangement between the federal government and the states, under which both the federal government and a participating state contribute financial support. The state, however, retains a considerable amount of discretion over the operation and administration of the program, and has the right to determine the benefits to be provided, rules for eligibility, rates of payment for services and other matters, as long as broad regulatory guidelines established by the federal government are followed.							
421-DL	PRIMARY CARE PROVIDER ID	ID assigned to the primary care provider. Used when the patient is referred to a secondary care provider.	n/a	S	C/P	A/N	15	1284	1298	
716-SY	LAST NAME	Last name	n/a	S	P	A/N	35	1299	1333	
717-SX	FIRST NAME	First name	n/a	S	P	A/N	35	1334	1368	
SECTION DENOTES CLAIM CATEGORY:										
399	RECORD STATUS CODE	Identifies the transaction status as assigned by the processor.	*Paid* – Code indicating that the transaction was adjudicated using plan rules and was payable. 2- *Rejected* – Code indicating that the transaction was denied/rejected 3- *Reversed* – Code indicating that the paid transaction was cancelled 4- *Adjusted* – Code indicating that the previous transaction was changed 5- Captured – Code indicating the receipt of the transaction but no judgment has been made regarding eligibility of the patient or payment. 6- *Reverse* – Captured- Code indicating that the captured transaction was cancelled.	M	P	A/N	1	1369	1369	
218	CLAIM MEDIA TYPE	Claim submission type code.	Blank-Not Specified	M	P	A/N	1	1370	1370	

			POS Claim –A Point-Of-Sale transaction submitted in a real-time mode. 2- *Batch Claim* – A non real-time transaction submitted when an immediate response is not available or required. 3- *Pharmacy Submitted Paper Claim (UCF)* – A non-electronic transaction submitted via an NCPDP-developed Universal Claim Form. 4- *Member Submitted Paper Claim (Direct Member Reimbursement (DMR)* – A claim submitted by the member requesting reimbursement. 5- *Other* – Different from the codes already specified							
395	PROCESSOR PAYMENT CLARIFICATION CODE	Provides additional information of the status of the payment of the claim.	Blank- Not Specified Ø1-Ø9- Paid 1Ø-19- Reversals 2Ø-29- Adjustments 3Ø-39- Rejects	M	P	A/N	2	1371	1372	SCDHHS requires “Blank” for this data element.
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/ Service Reference Number Qualifier	1- Rx Billing Transaction- A billing for a prescription or OTC drug product 2- *Service Billing* – Transaction is a billing for a professional service performed.	M	C	A/N	1	1373	1373	
402-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	n/a	M	C	N	12	1374	1385	PRESCRIPTION NUMBER
436-E1	PRODUCT/SERVICE ID QUALIFIER	Code qualifying the value in ‘Product/Service ID’ (4Ø7-D7).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 10- PPAC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID	M	C	A/N	2	1386	1387	

			31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 34- UPN 36- NDC 99- Other							
407-D7	PRODUCT/SERVICE ID	ID of the product dispensed or service provided.	n/a	M	C	A/N	19	1388	1406	NDC drug code if a compound drug is being reported, this field should be all zeros.
401-D1	DATE OF SERVICE	Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.	n/a	M	C	N	8	1407	1414	CCYYMMDD
578	ADJUDICATION DATE	Date the claim or adjustment is processed.	n/a	M	P	N	8	1415	1422	
203	ADJUDICATION TIME	Time the claim or adjustment is processed.	n/a	S	P	N	6	1423	1428	
283	ORIGINAL CLAIM RECEIVED DATE	The date the pharmacy submitted the claim electronically for a paper claim-matching program.	n/a	S	P	N	8	1429	1436	
219	CLAIM SEQUENCE NUMBER	Indicates the sequence of this claim within the set of claims submitted.	n/a	S	P	N	5	1437	1441	
213	BILLING CYCLE END DATE	Cycle end date.	n/a	S	P	N	8	1442	1449	
239	COMMUNICATION TYPE INDICATOR	For Mail Service Claims Only – Identifies the type of communication used by either prescriber or	Blank- Not Specified E- *Email (Electronic mail)* –The exchange of electronic messages and computer files between computers that are connected to the Internet or some other computer network.	S	P	A/N	2	1450	1451	

		patient to initiate the request for the fill.	F- *Fax* – Prescription obtained via transmission using a fax machine. *Interactive Voice Response Unit (IVRU)* – a phone technology that allows a computer to detect voice and touch tones using a normal phone call. The IVRU system can respond CODE DESCRIPTION with pre-recorded or dynamically generated audio to further direct callers on how to proceed. IVRU systems can be used to control almost any function where the interface can be broken down into a series of simple menu choices. D- *Directly delivered to pharmacy (delivery service/mail/walk in)* –delivered to the pharmacy personally P- *Electronic Prescription* – a computer based means of transmitting a prescription V- *Customer Service (phoned in)* – Use of a telephone to communicate information W- *Website* – A site (location) on the World Wide Web. Each website contains a homepage, which is the first document users see when they enter the site. The site might also contain additional documents and files. Each site is owned and managed by an individual, company, or organization.							
307-C7	PLACE OF SERVICE	Code identifying the place where a drug or service is dispensed or administered.	The Centers for Medicare and Medicaid Services (CMS) maintains this code set. The complete code set is available at: https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html	S	C	N	2	1452	1453	
384-4X	PATIENT RESIDENCE	Code identifying the patient's place of residence.	Ø- *Not Specified* – Other patient residence not identified below. *Home* – Location, other than a hospital or other facility, where the patient receives drugs or services in a private residence.	S	C	N	2	1454	1455	

			2- *Skilled Nursing Facility* – A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative service but does not provide the level of care or treatment available in a hospital. For Medicare Part B use only. 3- Nursing Facility – A facility which primarily provides to resident's skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. 4- *Assisted Living Facility* – Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. 5- *Custodial Care Facility* – A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. For Medicare Part B use only. 6- *Group Home* – Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community. 7- *Inpatient Psychiatric Facility* – A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. Not applicable to Pharmacy Benefits 8- *Psychiatric Facility – Partial Hospitalization* – A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. Not applicable to Pharmacy Benefits 9- *Intermediate Care Facility/Mentally Retarded* – A facility which primarily provides health-related care and services above the level of custodial care to							

			mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF. 10- *Residential Substance Abuse Treatment Facility* – A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. Not applicable to Pharmacy Benefits 11- *Hospice* – A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. 12- *Psychiatric Residential Treatment Facility* – A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. Not applicable to Pharmacy Benefits 13- *Comprehensive Inpatient Rehabilitation Facility* – A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services. Not applicable to Pharmacy Benefits 14- *Homeless Shelter* – A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). Not applicable to Pharmacy Benefits 15- *Correctional Institution* – A facility that provides treatment and rehabilitation of offenders through a program of penal custody.							
419-DJ	PRESCRIPTION ORIGIN CODE	Code indicating the origin of the prescription.	Ø- Not Known *Written* – Prescription obtained via paper. 2- *Telephone* – Prescription obtained via oral instructions or interactive voice response using a phone. 3- *Electronic* – Prescription obtained via SCRIPT or HL7 Standard transactions.	S	C	N	1	1456	1456	

			4- *Facsimile* – Prescription obtained via transmission using a fax machine. 5- *Pharmacy* – This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, interchange transfers, file buys, software							
278	MEMBER SUBMITTED CLAIM PAYMENT RELEASE DATE	Indicates the date the member submitted claim became payable, which could differ from the check date.	n/a	S	P	N	8	1457	1464	
217	CLAIM DATE RECEIVED IN THE MAIL	Date paper claim was received in the mail.	n/a	S	P	N	8	1465	1472	
268	INTERNAL MAIL ORDER PRESCRIPTION/SERVICE REFERENCE NUMBER	Field designating the internal prescription number assigned by pharmacies.	n/a	S	P	A/N	15	1473	1487	
102-A2	VERSION/RELEASE NUMBER (OF THE CLAIM)	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	4.2- 42	S	C	A/N	2	1488	1489	SCDHHS uses 4.2- “42”
216	CHECK DATE	Member Claims – Actual member check date Nonmember Claims – Pharmacy check date	n/a	S	P	N	8	1490	1497	Date Claim Paid Mask: CCYYMMDD
287	PAYMENT/ REFERENCE ID	Identifies ID assigned by sender to reference individual pharmacy and member reimbursement. Check or EFT trace number.	n/a	S	P	A/N	30	1498	1527	
456-EN	ASSOCIATED PRESCRIPTION/ SERVICE REFERENCE NUMBER	Related ‘Prescription/Service Reference Number’ (4Ø2-D2) to which the service is associated.	n/a	S	C	N	12	1528	1539	
457-EP	ASSOCIATED PRESCRIPTION/ SERVICE DATE	Date of the ‘Associated Prescription/Service	n/a	S	C	N	8	1540	1547	

		Reference Number' (456-EN).								
442-E7	QUANTITY DISPENSED	Quantity dispensed expressed in metric decimal units.	n/a	S	C	N	10	1548	1557	Quantity dispensed if a compound drug is being reported. This field should be all zeros.
403-D3	FILL NUMBER	The code indicating whether the prescription is an original or a refill.	Ø- Original dispensing – The first dispensing 1-99- Refill number – Number of the replenishment	S	C	N	2	1558	1559	Indicates new RX (blank) or number of refills used
405-D5	DAYS SUPPLY	Estimated number of days the prescription will last.	n/a	S	C	N	3	1560	1562	Days Supply Dispensed
414-DE	DATE PRESCRIPTION WRITTEN	Date prescription was written.	n/a	S	C	N	8	1563	1570	
	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	Ø- *No Product Selection Indicated* – This is the field default value that is appropriately used for prescriptions for single source brand, co-branded/co-licensed, or generic products. For a multi-source branded product with available generic(s), DAW Ø is not appropriate, and may result in a reject. 1- Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification. 2- *Substitution Allowed-Patient Requested Product Dispensed* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 3- *Substitution Allowed-Pharmacist Selected Product Dispensed* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the	S	C	A/N	1	1571	1571	

			prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. 4- *Substitution Allowed-Generic Drug Not in Stock* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace. 5- *Substitution Allowed-Brand Drug Dispensed as a Generic* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity. 6- *Override*-This value is used by various claims processors in very specific instances as defined by that claims' processor and/or its client(s). 7- *Substitution Not Allowed-Brand Drug Mandated by Law* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace. 8- *Substitution Allowed-Generic Drug Not Available in Marketplace* – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. 9- *Substitution Allowed By Prescriber but Plan Requests Brand* – Patient's Plan Requested Brand Product To Be Dispensed – This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.							

415-DF	NUMBER OF REFILLS AUTHORIZED	Number of refills authorized by the prescriber.	Ø- No refills authorized 1-99- Authorized Refill number – with 99 being as needed, refills unlimited	S	C	N	2	1572	1573	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	1- Not Specified 2- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	1574	1574	
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1575	1576	
418-DI	LEVEL OF SERVICE	Coding indicating the type of service the provider rendered.	Ø- *Not Specified* 1- Patient consultation – A professional service involving provider/patient discussion of disease, therapy or medication regimen, or other health issues 2- *Home delivery* – A provision of medications from pharmacy to patient's place of residence	S	C	N	2	1577	1578	

			3- *Emergency* – An urgent provision of care 4- *24 hour service* – A provision of care throughout the day and night 5- *Patient consultation regarding generic product selection* – A professional service involving discussion of alternatives to brand-name medications 6- *In-Home Service* – A provision of care in patient's place of residence							
343-HD	DISPENSING STATUS	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	Blank- *Not Specified* P- *Partial Fill* – A dispensing of less than the prescribed quantity, the balance of which will be dispensed at a later time. C- *Completion of Partial Fill* – Dispensing the remaining quantity of a prescription when the entire amount could not be supplied at the original dispensing (fill).	S	C	A/N	1	1579	1579	
344-HF	QUANTITY INTENDED TO BE DISPENSED	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	n/a	S	C	N	10	1580	1589	
460-ET	QUANTITY PRESCRIBED	Amount expressed in metric decimal units.	n/a	S	C	N	10	1590	1599	
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Days' supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	n/a	S	C	N	3	1600	1602	
254	FILL NUMBER CALCULATED	Code identifying whether the prescription is an original (ØØ) or by	Ø- New – Original 1-99- Refill number – Number of the replenishment	S	P	N	2	1603	1604	

		refill number (Ø1-99) as calculated by system based on historical claims data. This field represents the Fill Number as calculated (not submitted by pharmacy)								
406-D6	COMPOUND CODE	Code indicating whether or not the prescription is a compound.	0- Not Specified 1- Not a Compound – Medication that is available commercially as a dispensable product 2- *Compound* – Customized medication prepared in a pharmacy by combining, mixing, or altering of ingredients (but not reconstituting) for an individual patient in response to a licensed practitioner's prescription	S	C	N	1	1605	1605	
996-G1	COMPOUND TYPE	Clarifies the type of compound.	Ø1- *Anti-infective* – A medicinal product intended to treat pathogens such as bacteria, viruses, fungi or parasites Ø2- *Ionotropic* – A medicinal product intended to correct irregular heart rhythms Ø3- *Chemotherapy* – A medicinal product intended to treat cancer Ø4- *Pain management* – A regimen of therapy intended to ameliorate mild to severe discomfort Ø5- *TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition* – Products intended to provide nourishment by central or peripheral veins for patients with compromised digestive tracts Ø6- *Hydration* – A product intended to restore body fluids Ø7- *Ophthalmic* – A product intended to be applied to or instill in the surface of the eye 99- *Other* – Not defined by other available codes	S	C	A/N	2	1606	1607	
452-EH	COMPOUND ROUTE OF ADMINISTRATION	Code for the route of administration of the complete compound mixture.	NO LONGER USED FOR VERSION 4.2	S	C	N	2	1608	1609	NO LONGER USED FOR VERSION 4.2
995-E2	ROUTE OF ADMINISTRATION	This is an override to the "default" route referenced for the product. For a multi-	Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the International Health Terminology Standards	S	C	A/N	11	1610	1620	

		ingredient compound, it is the route of the complete compound mixture.	Development Organization (IHTSDO) http://www.ihtsdo.org/snomed-ct/							
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	*ØØ- Not Specified* Only to be used when needed to conform in fixed file layout specifications. Ø1- *International Classification of Diseases (ICD9)* – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. Ø2- *International Classification of Diseases-1Ø* – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. Ø3- *National Criteria Care Institute (NCCI)* – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding	S	C	A/N	2	1621	1622	

			guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Ø4- *The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED)* – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- *Common Dental Terminology (CDT)* – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- *American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)* – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1623	1637	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- *Not Specified* Only to be used when needed to conform in fixed file layout specifications. Ø1- *International Classification of Diseases (ICD9)* – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health	S	C	A/N	2	1638	1639	

			Organization and published by the Centers for Medicare and Medicaid Services. Ø2- *International Classification of Diseases-1Ø* – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. Ø3- *National Criteria Care Institute (NCCI)* – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Ø4- *The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED)* – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- *Common Dental Terminology (CDT)* – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental							

			Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- *American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)* – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1640	1654	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- *Not Specified* Only to be used when needed to conform in fixed file layout specifications. Ø1- *International Classification of Diseases (ICD9)* – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. Ø2- *International Classification of Diseases-1Ø* – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by	S	C	A/N	2	1655	1656	

			the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. Ø3- *National Criteria Care Institute (NCCI)* – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Ø4- *The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED)* – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- *Common Dental Terminology (CDT)* – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- *American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)* – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							

424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1657	1671	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	ØØ- *Not Specified* Only to be used when needed to conform in fixed file layout specifications. Ø1- *International Classification of Diseases (ICD9)* – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. Ø2- *International Classification of Diseases-1Ø* – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. Ø3- *National Criteria Care Institute (NCCI)* – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis	S	C	A/N	2	1672	1673	

			of standard medical and surgical practices, and a review of current coding practices. Ø4- *The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED)* – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- *Common Dental Terminology (CDT)* – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- *American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)* – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1674	1688	
492-WE	DIAGNOSIS CODE QUALIFIER	Code qualifying the 'Diagnosis Code' (424-DO).	*ØØ- Not Specified* Only to be used when needed to conform in fixed file layout specifications. Ø1- *International Classification of Diseases (ICD9)* – Code indicating the diagnosis is defined according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most codes are numeric and consist of 3, 4, or 5 numbers and a description. The codes are maintained by the World Health	S	C	A/N	2	1689	1690	

			Organization and published by the Centers for Medicare and Medicaid Services. Ø2- *International Classification of Diseases-1Ø* – Clinical Modifications (ICD-1Ø-CM) – Code indicating that the following information is a diagnosis as defined by ICD-1Ø-CM. As of January 1, 1999, the ICD-1Ø is used to code and classify mortality data from death certificates. The International Classification of Diseases, 1Øth Revision, Clinical Modification (ICD-9-CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. The codes are 3 to 7 digits with the first digit alpha, the second and third numeric and the remainder A/N. The codes are maintained by the World Health Organization and published by the Centers for Medicare and Medicaid Services. From the code set maintainer: The ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is not included in the code. Ø3- *National Criteria Care Institute (NCCI)* – The CMS-developed Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Ø4- *The Systematized Nomenclature of Medicine Clinical Terms® (SNOMED)* – A clinical health care terminology and infrastructure that provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Ø5- *Common Dental Terminology (CDT)* – Current Dental Terminology (CDT) is the published Code on Dental Procedures and Nomenclature (the Code) providing descriptive terms, codes and guidance for the accurate reporting of dental procedures. The Code is maintained by the Code Revision Committee and published by the American Dental							

			Association. The procedure codes and descriptions are also published as part of the Healthcare Common Procedure System (HCPCS) Level II through agreement with Centers for Medicare and Medicaid Services. Ø7- *American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV)* – Diagnostic criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. Comments: The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) is published by the American Psychiatric Association, Washington D.C.							
424-DO	DIAGNOSIS CODE	Code identifying the diagnosis of the patient.	n/a	S	C	A/N	15	1691	1705	
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan. CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question.	S	C	A/N	2	1706	1707	

			DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days' supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range.						

			IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses. NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed							

			for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems. PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided.						

			PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- *Side Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females. TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient.						

			UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc. MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue.	S	C	A/N	2	1708	1709	

			PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient. TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be							

			used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber.	S	C	A/N	2	1710	1711	

			3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time. 12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time.	S	C	N	2	1712	1713	

			13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan. CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment.	S	C	A/N	2	1714	1715	

			DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted.						

			EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses. NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a							

			claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems. PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with							

			the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females. TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a						

			laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc. MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient.	S	C	A/N	2	1716	1717	

			MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient. TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient.							

			TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the recommended medication(s) after consultation with the prescriber.	S	C	A/N	2	1718	1719	

			3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time. 12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or	S	C	N	2	1720	1721	

			complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan. CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or	S	C	A/N	2	1722	1723	

			potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient beyond the simple task of explaining the prescriber's instructions on the prescription.							

			ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is “locked in” to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days’ supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product’s common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product’s common uses. NA- *Drug Not Available*. – Indicates the drug is not currently available from any source.							

			NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1724	1725	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1726	1727	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1728	1729	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1730	1731	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1732	1733	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1734	1735	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1736	1737	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1738	1739	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1740	1741	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1742	1743	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1744	1745	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1746	1747	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1748	1749	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1750	1751	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1752	1753	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1754	1755	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1756	1757	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1758	1759	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- *Not Specified* 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1760	1761	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1762	1763	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1764	1765	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1766	1767	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1768	1769	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
439-E4	REASON FOR SERVICE CODE	Code identifying the type of utilization conflict detected by the prescriber or the pharmacist or the reason for the pharmacist's professional service.	AD- *Additional Drug Needed* – Code indicating optimal treatment of the patient's condition requiring the addition of a new drug to the existing drug therapy AN- *Prescription Authentication* – Code indicating that circumstances required the pharmacist to verify the validity and/or authenticity of the prescription. AR- *Adverse Drug Reaction* – Code indicating an adverse reaction by a patient to a drug. AT- *Additive Toxicity* – Code indicating a detection of drugs with similar side effects when used in combination could exhibit a toxic potential greater than either agent by itself. CD- *Chronic Disease Management* – The patient is participating in a coordinated health care intervention program. CH- *Call Help Desk* – Processor message to recommend the receiver contact the processor/plan.	S	C	A/N	2	1770	1771	

			CS- *Patient Complaint/Symptom*- Code indicating that in the course of assessment or discussion with the patient, the pharmacist identified an actual or potential problem when the patient presented to the pharmacist complaints or symptoms suggestive of illness requesting evaluation and treatment. DA- *Drug-Allergy* – Indicates that an adverse immune event may occur due to the patient's previously demonstrated heightened allergic response to the drug product in question. DC- *Drug-Disease (Inferred)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. The existence of the specific medical condition is inferred from drugs in the patient's medication history. DD- *Drug-Drug Interaction* – Indicates that drug combinations in which the net pharmacologic response may be different from the result expected when each drug is given separately. DF- *Drug-Food interaction* – Indicates interactions between a drug and certain foods. DI- *Drug Incompatibility* – Indicates physical and chemical incompatibilities between two or more drugs. DL- *Drug-Lab Conflict* – Indicates that laboratory values may be altered due to the use of the drug, or that the patient's response to the drug may be altered due to a condition that is identified by a certain laboratory value. DM- *Apparent Drug Misuse* – Code indicating a pattern of drug use by a patient in a manner that is significantly different than that prescribed by the prescriber. DR- *Dose Range Conflict* – Code indicating that the prescription does not follow recommended medication dosage. DS- *Tobacco Use* – Code indicating that a conflict was detected when a prescribed drug is contraindicated or might conflict with the use of tobacco products. ED- *Patient Education/Instruction* – Code indicating that a cognitive service whereby the pharmacist performed a patient care activity by providing additional instructions or education to the patient							

			beyond the simple task of explaining the prescriber's instructions on the prescription. ER- *Overuse* – Code indicating that the current prescription refill is occurring before the days supply of the previous filling should have been exhausted. EX- *Excessive Quantity* – Code that documents the quantity is excessive for the single time period for which the drug is being prescribed. HD- *High Dose* – Detects drug doses that fall above the standard dosing range. IC-*Iatrogenic Condition* – Code indicating that a possible inappropriate use of drugs that are designed to ameliorate complications caused by another medication has been detected. ID- *Ingredient Duplication* – Code indicating that simultaneous use of drug products containing one or more identical generic chemical entities has been detected. LD- *Low Dose* – Code indicating that the submitted drug doses fall below the standard dosing range. LK- *Lock In Recipient* – Code indicating that the professional service was related to a plan/payer constraint on the member whereby the member is required to obtain services from only one specified pharmacy or other provider type, hence the member is "locked in" to using only those providers or pharmacies. LR-*Underuse* – Code indicating that a prescription refill that occurred after the days' supply of the previous filling should have been exhausted. MC- *Drug-Disease (Reported)* – Indicates that the use of the drug may be inappropriate in light of a specific medical condition that the patient has. Information about the specific medical condition was provided by the prescriber, patient or pharmacist. MN-*Insufficient Duration* – Code indicating that regimens shorter than the minimal limit of therapy for the drug product, based on the product's common uses, has been detected. MS- *Missing Information/Clarification* – Code indicating that the prescription order is unclear, incomplete, or illegible with respect to essential information. MX- *Excessive Duration* – Detects regimens that are longer than the maximal limit of therapy for a drug product based on the product's common uses.							

			NA- *Drug Not Available*. – Indicates the drug is not currently available from any source. NC- *Non-covered Drug Purchase* – Code indicating a cognitive service whereby a patient is counseled, the pharmacist's recommendation is accepted and a claim is submitted to the processor requesting payment for the professional pharmacy service only, not the drug. ND- *New Disease/Diagnosis* – Code indicating that a professional pharmacy service has been performed for a patient who has a newly diagnosed condition or disease. NF- *Non-Formulary Drug* – Code indicating that mandatory formulary enforcement activities have been performed by the pharmacist when the drug is not included on the formulary of the patient's pharmacy benefit plan. NN- *Unnecessary Drug* – Code indicating that the drug is no longer needed by the patient. NP- *New Patient Processing* – Code indicating that a pharmacist has performed the initial interview and medication history of a new patient. NR- *Lactation/Nursing Interaction* – Code indicating that the drug is excreted in breast milk and may represent a danger to a nursing infant. NS- *Insufficient Quantity* – Code indicating that the quantity of dosage units prescribed is insufficient. OH- *Alcohol Conflict* – Detects when a prescribed drug is contraindicated or might conflict with the use of alcoholic beverages. PC- *Patient Question/Concern* – Code indicating that a request for information/concern was expressed by the patient, with respect to patient care. PG- *Drug-Pregnancy* – Indicates pregnancy related drug problems. This information is intended to assist the healthcare professional in weighing the therapeutic value of a drug against possible adverse effects on the fetus. PH- *Preventive Health Care* – Code indicating that the provided professional service was to educate the patient regarding measures mitigating possible adverse effects or maximizing the benefits of the product(s) dispensed; or measures to optimize health status, prevent recurrence or exacerbation of problems.							

			PN- *Prescriber Consultation* – Code indicating that a prescriber has requested information or a recommendation related to the care of a patient. PP- *Plan Protocol* – Code indicating that a cognitive service whereby a pharmacist, in consultation with the prescriber or using professional judgment, recommends a course of therapy as outlined in the patient's plan and submits a claim for the professional service provided. PR- *Prior Adverse Reaction* – Code identifying the patient has had a previous atypical reaction to drugs. PS- *Product Selection Opportunity* – Code indicating that an acceptable generic substitute or a therapeutic equivalent exists for the drug. This code is intended to support discretionary drug product selection activities by pharmacists. RE- *Suspected Environmental Risk*- Code indicating that the professional service was provided to obtain information from the patient regarding suspected environmental factors. RF- *Health Provider Referral* – Patient referred to the pharmacist by another health care provider for disease specific or general purposes. SC- *Suboptimal Compliance* – Code indicating that professional service was provided to counsel the patient regarding the importance of adherence to the provided instructions and of consistent use of the prescribed product including any ill effects anticipated as a result of non-compliance. SD- *Suboptimal Drug/Indication* – Code indicating incorrect, inappropriate, or less than optimal drug prescribed for the patient's condition. SE- S*ide Effect* – Code reporting possible major side effects of the prescribed drug. SF- *Suboptimal Dosage Form* – Code indicating incorrect, inappropriate, or less than optimal dosage form for the drug. SR- *Suboptimal Regimen* – Code indicating incorrect, inappropriate, or less than optimal dosage regimen specified for the drug in question. SX- *Drug-Gender* – Indicates the therapy is inappropriate or contraindicated in either males or females.							

			TD- *Therapeutic* – Code indicating that a simultaneous use of different primary generic chemical entities that have the same therapeutic effect was detected. TN- *Laboratory Test Needed* – Code indicating that an assessment of the patient suggests that a laboratory test is needed to optimally manage a therapy. TP- *Payer/Processor Question* – Code indicating that a payer or processor requested information related to the care of a patient. UD- *Duplicate Drug* – Code indicating that multiple prescriptions of the same drug formulation are present in the patient's current medication profile.							
440-E5	PROFESSIONAL SERVICE CODE	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	*No intervention*. AS- *Patient Assessment* – Code indicating that an initial evaluation of a patient or complaint/symptom for the purpose of developing a therapeutic plan. CC- *Coordination of Care* – Case management activities of a pharmacist related to the care being delivered by multiple providers. DE- *Dosing Evaluation/determination* – Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation. DP- *Dosage Evaluated* – Code indicating that dosage has been evaluated with respect to risk for the patient. FE- *Formulary Enforcement* – Code indicating that activities including interventions with prescribers and patients related to the enforcement of a pharmacy benefit plan formulary have occurred. Comment: Use this code for cross-licensed brand products or generic to brand interchange. GP- *Generic Product Selection* – The selection of a chemically and therapeutically identical product to that specified by the prescriber for the purpose of achieving cost savings for the payer. M0- *Prescriber Consulted* – Code indicating prescriber communication related to collection of information or clarification of a specific limited problem. MA- *Medication Administration* – Code indicating an action of supplying a medication to a patient through any of several routes-oral, topical, intravenous, intramuscular, intranasal, etc.	S	C	A/N	2	1772	1773	

			MB- *Overriding Benefit* – Benefits of the prescribed medication outweigh the risks. MP- *Patient will be Monitored* – Prescriber is aware of the risk and will be monitoring the patient. MR- *Medication Review* – Code indicating comprehensive review and evaluation of a patient's entire medication regimen. PA- *Previous Patient Tolerance* – Patient has taken medication previously without issue. PE- *Patient Education/instruction* – Code indicating verbal and/or written communication by a pharmacist to enhance the patient's knowledge about the condition under treatment or to develop skills and competencies related to its management. PH- *Patient Medication History* – Code indicating the establishment of a medication history database on a patient to serve as the foundation for the ongoing maintenance of a medication profile. PM- *Patient Monitoring* – Code indicating the evaluation of established therapy for the purpose of determining whether an existing therapeutic plan should be altered. P0- *Patient Consulted* – Code indicating patient communication related to collection of information or clarification of a specific limited problem. PT- *Perform Laboratory Test* – Code indicating that the pharmacist performed a clinical laboratory test on a patient. R0- *Pharmacist Consulted Other Source* – Code indicating communication related to collection of information or clarification of a specific limited problem. RT- *Recommend Laboratory Test* – Code indicating that the pharmacist recommends the performance of a clinical laboratory test on a patient. SC- *Self-care Consultation* – Code indicating activities performed by a pharmacist on behalf of a patient intended to allow the patient to function more effectively on his or her own behalf in health promotion and disease prevention, detection, or treatment. SW- *Literature Search/review* – Code indicating that the pharmacist searches or reviews the pharmaceutical and/or medical literature for information related to the care of a patient.							

			TC- *Payer/processor Consulted* – Code indicating communication by a pharmacist to a processor or payer related to the care of the patient. TH- *Therapeutic Product Interchange* – Code indicating that the selection of a therapeutically equivalent product to that specified by the prescriber for the purpose of achieving cost savings for the payer. ZZ- *Other Acknowledgement*. When ZZ is used, the textual DUE Acknowledgment Reason must be used to provide additional detail.							
441-E6	RESULT OF SERVICE CODE	Action taken by a pharmacist or prescriber in response to a conflict or the result of a pharmacist's professional service.	1K- *Filled with Different Dosage Form* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert) and fills the prescription with a different dosage form than was originally prescribed. 2A- *Prescription* Not Filled – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert) and determines that the prescription should not be filled as written. 2B- *Not Filled, Directions Clarified* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or using professional judgment, does not fill the prescription and counsels the patient as to the prescriber's instructions. 3A- *Recommendation Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3B- *Recommendation Not Accepted* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen but the prescriber does not concur. 3C- *Discontinued Drug* – Cognitive service involving the pharmacist's review of drug therapy that results in the removal of a medication from the therapeutic regimen. 3D- *Regimen Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate regimen then dispenses the	S	C	A/N	2	1774	1775	

			recommended medication(s) after consultation with the prescriber. 3E- *Therapy Changed* – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen then dispenses the alternative after consultation with the prescriber. 3F- *Therapy Changed* – Cost increased acknowledged – Code indicating a cognitive service. The pharmacist reviews and evaluates a therapeutic issue (alert), recommends a more appropriate product or regimen acknowledging that a cost increase will be incurred, then dispenses the alternative after consultation with the prescriber. 3G- *Drug Therapy Unchanged* – Cognitive service whereby the pharmacist reviews and evaluates a therapeutic issue (alert), consults with the prescriber or uses professional judgment and subsequently fills the prescription as originally written. 3H- *Follow-Up/Report* – Code indicating that additional follow through by the pharmacist is required. 3J- *Patient Referral* – Code indicating the referral of a patient to another health care provider following evaluation by the pharmacist. 3K- *Instructions Understood* – Indicator used to convey that the patient affirmed understanding of the instructions provided by the pharmacist regarding the use and handling of the medication dispensed. 3M- *Compliance Aid Provided* – Cognitive service whereby the pharmacist supplies a product that assists the patient in complying with instructions for taking medications. 3N- *Medication Administered* – Cognitive service whereby the pharmacist performs a patient care activity by personally administering the medication. 4A- *Prescribed with acknowledgements* – Physician is prescribing this medication with knowledge of the potential conflict.							
474-8E	DUR/PPS LEVEL OF EFFORT	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a	Ø- Not Specified 11- *Level 1 (Lowest)* = Straightforward: Service involves minimal diagnosis or treatment options, minimal amount or complexity of data considered, and minimal risk; AND/OR Requires 1 to 4 MINUTES of the pharmacist's time.	S	C	N	2	1776	1777	

		pharmacist to perform a professional service.	12- *Level 2 (Low Complexity)* = Service involves limited diagnosis or treatment options, limited amount or complexity of data considered, and low risk; AND/OR Requires 5 to 14 MINUTES of the pharmacist's time. 13- *Level 3 (Moderate Complexity)* = Service involves moderate diagnosis or treatment options, moderate amount or complexity of data considered, and moderate risk; AND/OR Requires 15 to 29 MINUTES of the pharmacist's time. 14- *Level 4 (High Complexity)* = Service involves multiple diagnosis or treatment options, extensive amount or complexity of data considered, and high risk; AND/OR Requires 30 to 59 minutes of the pharmacist's time. 15- *Level 5 (Highest)* = Comprehensive: Service involves extensive diagnosis or treatment options, exceptional amount or complexity of data considered, and very high risk; AND/OR Counseling or coordination of care dominated the encounter and requires equal to or greater than 60 minutes of the pharmacist's time.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10	S	C	A/N	2	1778	1779	

			23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1780	1798	
878	REJECT OVERRIDE CODE	Indicates the reason for paying a claim when override is used.	Blank- *Not Specified* *Ø- Claim Was Paid In Good Faith* 1- Member *Was Ineligible On Rx Date* 2- *Member Was Not Found On The Member Master On Rx Date* 3- *Claim Was Filled For A Terminated Member*	S	P	A/N	1	1799	1799	
511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also “Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging” of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the	S	C	A/N	3	1800	1802	

			field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)							
511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also “Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging” of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)	S	C	A/N	3	1803	1805	
511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also “Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging” of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)	S	C	A/N	3	1806	1808	
511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also “Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging” of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)	S	C	A/N	3	1809	1811	

511-FB	REJECT CODE	Code indicating the error encountered.	Used for the Telecommunication and Financial Information Reporting Standards. All reject codes listed are used in the Telecommunication Standard unless otherwise stated. Reject Codes used in the Financial Information Reporting (FIR) Standard are noted. See also "Appendix G. Two-Way Communication to Increase the Value of On-Line Messaging" of the Telecommunication Standard Implementation Guide. (NOTE: Reject Codes added for and pertaining to specific fields may not be used in versions of the standards that were in effect prior to the addition of the field(s) to the standards. Refer to the Standard/Version Formats Column of field 511-FB for Standards Use.)	S	C	A/N	3	1812	1814	
SECTION DENOTES WORKERS COMPENSATION CATEGORY:										
435-DZ	CLAIM/REFERENCE ID	Identifies the claim number assigned by Worker's Compensation Program.	n/a	S	C	A/N	30	1815	1844	
434-DY	DATE OF INJURY	Date on which the injury occurred.	n/a	S	C	N	8	1845	1852	
SECTION DENOTES PRODUCT CATEGORY:										
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- First DataBank – A drug database company 2- *Medi-Span Product Line* – A drug database company 3- *Micromedex/Medical Economics* – A drug database company 4- *Processor Developed* – A proprietary drug file 5- *Other* – Different from those implied or specified 6- *Redbook* – A Micromedex publication of drug information 7- *Multum* – Drug database company	S	P	A/N	1	1853	1853	
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1854	1883	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1884	1913	

601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	15	1914	1928	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1929	1932	
	FILLER	n/a	n/a	S	P	A/N	8	1933	1940	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	N	1	1941	1941	
273	MAINTENANCE DRUG INDICATOR	Indicates if the drug is a maintenance drug under the client's benefit plan.	Blank- *Not Specified* Y- *Maintenance Drug* – Medication used to treat a chronic condition. N- *Not Maintenance* – Medication used to treat an acute condition.	S	P	A/N	1	1942	1942	
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1943	1943	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- *Schedule II Narcotic Substances* 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1944	1944	
297	PRESCRIPTION OVER THE COUNTER INDICATOR	The indicator that specifies this prescription is a federal/legend (RX prescription only) or non-prescription drug (OTC).	Blank- *Not Specified* O- *Over the counter (OTC)* – prescription not required to be dispensed F- *Federal/Legend (Rx Prescription Only)* S- *State Restricted Medication* – Under federal law, the product as dispensed does not require a prescription, but is restricted to prescription sale at the state level.	S	P	A/N	1	1945	1945	

420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	9- Encounters	S	C	N	2	1946	1947	Use "9" – Encounters
420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	9- Encounters	S	C	N	2	1948	1949	
420-DK	SUBMISSION CLARIFICATION CODE	Code indicating that the pharmacist is clarifying the submission.	9- Encounters	S	C	N	2	1950	1951	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* *Ø- Was Drug Efficacy Study Implementation (DESI) – At One Time But No Longer* 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1952	1952	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	1953	1953	

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*							

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1954	1970	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	1971	1971	

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1972	1988	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	1989	1989	

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							

601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1990	2006	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	2007	2007	
294	PRESCRIBED DAYS SUPPLY	Indicates the original days supply of the prescription. Applies to internal Mail Service only.	n/a	S	P	N	3	2008	2010	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form.	S	P	A/N	1	2011	2011	

			8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type							

			Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2012	2028	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.	S	P	A/N	1	2029	2029	

			9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2030	2046	

601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and	S	P	A/N	1	2047	2047	

			toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2048	2064	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form,	S	P	A/N	1	2065	2065	

			and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to							

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601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	2066	2082	
SECTION DENOTES FORMULARY CATEGORY:										
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary,	S	P	A/N	1	2083	2083	

			and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified* Y- *Yes* N- *No*	S	P	A/N	1	2084	2084	
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	2085	2092	
256	FORMULARY FILE ID	Identifies the formulary ID used during adjudication of the claim.	n/a	S	P	A/N	15	2093	2107	
255	FORMULARY CODE TYPE	Indicates how the Formulary Benefit is set up. As defined by processor.	n/a	S	P	A/N	1	2108	2108	

SECTION DENOTES PRICING CATEGORY:										
506-F6	INGREDIENT COST PAID	Drug ingredient cost paid included in the "Total Amount Paid" (509-F9)	n/a	M	C	D	8	2109	2116	
507-F7	DISPENSING FEE PAID	Total amount to be paid by the claims processor.	n/a	M	C	D	8	2117	2124	
894	TOTAL AMOUNT PAID BY ALL SOURCES	Total amount of the prescription regardless of party responsible for payment.	n/a	M	P	D	8	2125	2132	**TOTAL AMOUNT PAID BY MCO**
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to sales tax paid.	n/a	S	C	D	8	2133	2140	
505-F5	PATIENT PAY AMOUNT	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc.	n/a	M	C	D	8	2141	2148	
518-FI	AMOUNT OF COPAY	Amount to be collected from the patient that is included in "Patient Pay Amount" that is due to per prescription coinsurance.	n/a	S	C	D	8	2149	2156	

572-4U	AMOUNT OF COINSURANCE	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the patient’s selection of a Brand product.	n/a	S	C	D	8	2157	2164	
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to per prescription copay.	n/a	S	C	D	8	2165	2172	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to a periodic deductible.	n/a	S	C	D	8	2173	2180	
571-NZ	AMOUNT ATTRIBUTED TO PROCESSOR FEE	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the processing fee imposed by the processor.	n/a	S	C	D	8	2181	2188	
133-UJ	AMOUNT ATTRIBUTED TO PROVIDER NETWORK SELECTION	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the patient’s provider network selection.	n/a	S	C	D	8	2189	2196	
134-UK	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND DRUG	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the patient’s selection of Brand product.	n/a	S	C	D	8	2197	2204	
135-UM	AMOUNT ATTRIBUTED TO PRODUCT	Amount to be collected from the patient that is included	n/a	S	C	D	8	2205	2212	

	SELECTION/NON-PREFERRED FORMULARY SELECTION	in “Patient Pay Amount” that is due to the patient’s selection of Non-Preferred Formulary product.								
136-UN	AMOUNT ATTRIBUTED TO PRODUCT SELECTION/BRAND NON-PREFERRED FORMULARY SELECTION	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the patient’s selection of a Brand Non-Preferred Formulary product.	n/a	S	C	D	8	2213	2220	
137-UP	AMOUNT ATTRIBUTED TO COVERAGE GAP	Amount to be collected from the patient that is included in “Patient Pay Amount” that is due to the patient being in the coverage gap (i.e. donut hole). A coverage gap is defined as the period or amount during which the previous coverage ends and before an additional coverage begins.	n/a	S	C	D	8	2221	2228	
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	2229	2229	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer.	S	P	A/N	2	2230	2231	

			Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	2232	2232	
284	OUT OF POCKET APPLY AMOUNT	Amount applied to the out of pocket expense.	n/a	S	P	D	8	2233	2240	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	2241	2249	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	2250	2258	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	2259	2267	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	2268	2276	
430-DU	GROSS AMOUNT DUE	Total price claimed from all sources.	n/a	S	C	D	8	2277	2284	Amount billed to the MCO (Amount being billed by the provider to the MCO) MASK 9999999V99 zero filled, no sign

271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	2285	2293	
409-D9	INGREDIENT COST SUBMITTED	Submitted product component cost of the dispensed prescription. This amount is included in the "Gross Amount Due (430-DU).	n/a	S	C	D	8	2294	2301	
426-DQ	USUAL AND CUSTOMARY CHARGE	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	n/a	S	C	D	8	2302	2309	
558-AW	FLAT SALES TAX AMOUNT PAID	Flat sales tax paid which is included in the total Amount Paid" (509-F()	n/a	S	C	D	8	2310	2317	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	Amount of percentage sales tax paid which is included in the "Total Amount Paid" (509-F9)	n/a	S	C	D	8	2318	2325	
560-AY	PERCENTAGE SALES TAX RATE PAID	Percentage sales tax rate used to calculate "Percentage Sales Tax Amount Paid" (559-AX)	n/a	S	C	D	7	2326	2332	
561-AZ	PERCENTAGE SALES TAX BASIS PAID	Code indicating the percentage sales tax.	Ø2- *Ingredient Cost* – The dollar amount/value of the prescription submitted by the pharmacist. Does not include sales tax or dispensing fee. Ø3- *Ingredient Cost + Dispensing Fee* – The dollar amount/value of the prescription submitted by the pharmacist plus dispensing fee. Ø4- *Professional Service Fee* – The dollar amount/value for the professional service.	S	C	A/N	2	2333	2334	

521-FL	INCENTIVE AMOUNT PAID	Amount represents the contractually agreed upon incentive fee paid for specific services rendered. Amount is included in the "Total Amount Paid" (509-F9)	n/a	S	C	D	8	2335	2342	
562-J1	PROFESSIONAL SERVICE FEE PAID	Amount representing the contractually agreed upon fee for professional services rendered. This amount is included in the "Total Amount Paid" (509-F9)	n/a	S	C	D	8	2343	2350	
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. 02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit.	S	C	A/N	2	2351	2352	

			09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. 11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.							
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other Amount Paid' (565-J4).	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. 02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax.	S	C	D	8	2353	2360	

			11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.							
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. 02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. 11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.	S	C	A/N	2	2361	2362	
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service.	S	C	D	8	2363	2370	

		Amount Paid' (565-J4).	02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. 11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.							
564-J3	OTHER AMOUNT PAID QUALIFIER	Code clarifying the value in the 'Other Amount Paid' (565-J4).	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. 02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection,	S	C	A/N	2	2371	2372	

			claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g. collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. 11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.							
565-J4	OTHER AMOUNT PAID	Code clarifying the value in the 'Other Amount Paid' (565-J4).	01- Delivery Cost – An indicator which signifies the amount claimed for the costs related to the delivery of a product or service. 02- *Shipping Cost* – The amount claimed for transportation of an item. 03- *Postage Cost* – The amount claimed for the mailing of an item. 04- *Administrative Cost* – An indicator conveying the following amount is related to the cost of activities such as utilization review, premium collection, claims processing, quality assurance, and risk management for purposes of insurance. 05- *Incentive* – An indicator which signifies the dollar amount paid by the other payer which is related to additional fees or compensations paid as an inducement for an action taken by the provider (e.g.	S	C	D	8	2373	2380	

			collection of survey data, counseling plan enrollees). 06- *Cognitive Service* – An indicator which signifies the dollar amount paid by the other payer which is related to the pharmacist's interaction with a patient or caregiver that is beyond the traditional dispensing/patient instruction activity (e.g. therapeutic regimen review; recommendation for additional, fewer or different therapeutic choices). 07- *Drug Benefit* – An indicator which signifies the dollar amount paid by the other payer which is related to the plan's drug benefit. 09- *Compound Preparation Cost Submitted* – The amount claimed for the preparation of the compound. 10- *Sales Tax* – An Indicator which signifies the dollar amount paid by the other payer which is related to Sales Tax. 11- *Medication Administration* – An indicator which signifies the dollar amount paid by the other payer which is related to the administration of the medication.							
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Total amount recognized by the processor of any payment from another source.	n/a	S	C	D	8	2381	2388	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded.	S	C	A/N	2	2389	2390	

			Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	2391	2400	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the	S	C	A/N	2	2401	2402	

			portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	2403	2412	

281	NET AMOUNT DUE	Net amount paid to provider by the payer or net amount due from the client to the payer, determined by trading partner agreement.	n/a	M	P	D	8	2413	2420	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	2421	2422	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. 08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL 00 = 'Z' which is for Zero billed/Provider did not charge
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	Amount in dollars met by the patient/family in a deductible plan.	n/a	S	C	D	8	2423	2430	
513-FD	REMAINING DEDUCTIBLE AMOUNT	Amount not met by the patient/family in the deductible plan.	n/a	S	C	D	8	2431	2438	
514-FE	REMAINING BENEFIT AMOUNT	Amount remaining in a patient/family plan with a periodic maximum benefit.	n/a	S	C	D	8	2439	2446	
242	COST DIFFERENCE AMOUNT	Difference between client contracted amount and the pharmacy or member submitted amount.	n/a	S	P	D	8	2447	2454	
249	EXCESS COPAY AMOUNT	Amount of the copay that exceeds the approved amount for this claim.	n/a	S	P	D	8	2455	2462	

277	MEMBER SUBMIT AMOUNT	Ingredient cost as submitted by member (paper claims only).	n/a	S	P	D	8	2463	2470	
265	HOLD HARMLESS AMOUNT	Amount payable to member when paper claims amount exceeds Pharmacy Network Reimbursement.	n/a	S	P	D	8	2471	2478	
520-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	Amount to be collected from the patient that is included in "Patient Pay Amount" (505-F5) that is due to the patient exceeding a periodic benefit maximum.	n/a	S	C	D	8	2479	2486	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	Code indicating how the reimbursement amount was calculated for "Dispensing Fee Paid" (507-F7)	Ø1- *Quantity Dispensed* – The quantity of the prescription dispensed for the patient. Ø2- *Quantity Intended To Be Dispensed* – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order. Ø3- *Usual and Customary/Prorated* – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated. Ø4- *Waived Due To Partial Fill* – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- *Other*	S	C	A/N	2	2487	2488	
347-HJ	BASIS OF CALCULATION – COPAY	Code indicating how the copay reimbursement amount was	Ø1- *Quantity Dispensed* – The quantity of the prescription dispensed for the patient. Ø2- *Quantity Intended To Be Dispensed* – Indicates that the originally intended quantity of an item as	S	C	A/N	2	2489	2490	

		calculated for "Dispensing Fee Paid" (505-F5)	written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order. Ø3- *Usual and Customary/Prorated* – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated. Ø4- *Waived Due To Partial Fill* – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- *Other* – Different from those implied or specified.							
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	Code indicating how the reimbursement amount was calculated for "Flat Sales Tax Amount Paid" (558-AW)	Blank- *Not Specified* *ØØ- Not Specified* Ø1- *Quantity Dispensed* – The quantity of the prescription dispensed for the patient. Ø2- *Quantity Intended To Be Dispensed* – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	S	C	A/N	2	2491	2492	
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	Code indicating how the reimbursement amount was calculated for "Percentage Sales Tax Amount Paid" (559-AX)	Blank- *Not Specified* *ØØ- Not Specified* Ø1- *Quantity Dispensed* – The quantity of the prescription dispensed for the patient. Ø2- *Quantity Intended To Be Dispensed* – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	S	C	A/N	2	2493	2494	
573-4V	BASIS OF CALCULATION – COINSURANCE	Code indicating how the coinsurance reimbursement amount was calculated for "Patient Pay Amount" (559-AX)	Ø1- *Quantity Dispensed* – The quantity of the prescription dispensed for the patient. Ø2- *Quantity Intended To Be Dispensed* – Indicates that the originally intended quantity of an item as written in the physician's order is being used for the calculation of this amount even if this transaction indicates a partial filling of the order.	S	C	A/N	2	2495	2496	

			Ø3- *Usual and Customary/Prorated* – Used when payment is based upon the submitted U&C value rather than the calculated/contracted rate, causing a situation where the copay/dispensing fee is higher than the U&C value, so the plan/processor returns a copay/dispensing fee to the provider which is less than the plan copay/dispensing fee, thereby being prorated. Ø4- *Waived Due To Partial Fill* – Due to the fact that the provider is submitting a partial fill transaction (no assumptions are being made as to whether this is the initial billing or the final billing in a partial fill situation), the plan/processor may elect not to apply a copay or a dispensing fee on one or both of those partial fill transactions. 99- *Other* – Different from those implied or specified.							
557-AV	TAX EXEMPT INDICATOR	Code indicating the payer and/or the patient is exempt from taxes.	Blank- *Not Specified* *Payer/Plan is Tax Exempt* – The Payer/Plan is not responsible for tax. The patient may be charged tax. 3- *Patient is Tax Exempt* – The patient cannot be charged tax. 4- *Payer/Plan and Patient are Tax Exempt* – Neither the payer/plan nor the patient can be charged tax.	S	C	A/N	1	2497	2497	
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	2498	2505	
276	MEDICARE RECOVERY INDICATOR	Field to indicate if Medicare was billed in order to recover funds for current or previous claims billed to the client.	Blank- *Not Specified* Ø- *No Medicare Recovery* – No demand for payment has been made by Medicare *Prospective Billing* – Demand for payment has been made before service provided 2- *Retrospective Billing* – Demand for payment has been made after service provided	S	P	A/N	1	2506	2506	
275	MEDICARE RECOVERY DISPENSING INDICATOR	Field to indicate if days' supply on prescription was reduced due to plan limits.	Blank- *Not Specified* Ø- *No reduction applied* 1- *Days supply reduced due to Client plan limitations* 2- *Days supply reduced due to Medicare Plan Limits* 3- *Prescribed Days Supply Dispensed based on Client Approval*	S	P	A/N	1	2507	2507	

286	PATIENT SPEND DOWN AMOUNT	Claim dollars applied to patients spend down account (example Flexible Spending Account).	n/a	S	P	D	8	2508	2515	
263	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT APPLIED	Health Care Reimbursement Account Amount Applied	n/a	S	P	D	8	2516	2523	
264	HEALTH CARE REIMBURSEMENT ACCOUNT AMOUNT REMAINING	Client-defined benefit that provides funds to patients that can be used to offset Out of Pocket expenses.	n/a	S	P	D	8	2524	2531	
207	ADMINISTRATIVE FEE EFFECT INDICATOR	Indicates how the transaction should be counted for administrative fee determination.	Blank- *Not Specified* A- *Add to count* S- *Subtracts from count*	S	P	A/N	1	2532	2532	
206	ADMINISTRATIVE FEE AMOUNT	Administrative fee charge per claim.	n/a	S	P	D	4	2533	2536	
269	INVOICED AMOUNT	Amount invoiced for this transaction. Determined by Processor.	n/a	S	P	D	11	2537	2547	
	FILLER	n/a	n/a	S	P	A/N	10	2548	2557	
128-UC	SPENDING ACCOUNT AMOUNT REMAINING	The balance from the patient's spending account after this transaction was applied.	n/a	S	C	D	8	2558	2565	
129-UD	HEALTH PLAN-FUNDED ASSISTANCE AMOUNT	The amount from the health plan-funded assistance account for the patient that was applied to reduce Patient Pay Amount (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This	n/a	S	C	D	8	2566	2573	

		field is always a negative amount or zero.								
SECTION DENOTES PRIOR AUTHORIZATION CATEGORY:										
461-EU	PRIOR AUTHORIZATION TYPE CODE	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction.	S	C	N	2	2574	2575	

			7- *TANF (Temporary Assistance for Needy Families)* – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Number submitted by the provider to identify the prior authorization.	n/a	S	C	N	11	2576	2586	SCDHHS will use this field to indicate the begin and the end date of an authorization. Use Julianne date.
498-PY	PRIOR AUTHORIZATION NUMBER – ASSIGNED	Unique number identifying the prior authorization assigned by the processor.	n/a	S	P	N	11	2587	2597	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required.	S	P	N	2	2598	2599	

			4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
SECTION DENOTES ADJUSTMENT CATEGORY:										
204	ADJUSTMENT REASON CODE	Reason for adjustment	n/a	S	P	N	3	2600	2602	
205	ADJUSTMENT TYPE	Type of adjustment.	Blank- *Not Specified* 1- Debit – An adjustment resulting in an increased payment amount. 2- *Credit* – An adjustment resulting in a decreased payment amount.	S	P	A/N	1	2603	2603	
897	TRANSACTION ID CROSS REFERENCE	For adjustments, ID associated with original claim.	n/a	S	P	A/N	30	2604	2633	
SECTION DENOTES COORDINATION OF BENEFITS CATEGORY:										

225	COB CARRIER SUBMIT AMOUNT	The amount submitted by the COB carrier.	n/a	S	P	D	8	2634	2641	
245	ELIGIBILITY COB INDICATOR	COB code as provided on Client eligibility.	Blank- *Not Specified* 1- Payer is Primary – Plan is first payer for patient 2- *Payer is Secondary* – Plan is second payer for patient 3- *Payer is Tertiary* – Plan is third payer for patient	S	P	A/N	1	2642	2642	
226	COB PRIMARY CLAIM TYPE	For secondary COB claims. Indicates the claim type of the primary claim.	Blank- *Not Specified* I- Secondary Claims Not Processed – Supplemental claims are not eligible for COB. J- *Major Medical* – Supplemental health care claims, excluding pharmaceutical claims, are eligible for COB M- *Mail Service* – Pharmaceutical claims dispensed out of a Mail Order Facility. R- *Retail* – Pharmaceutical claims dispensed out of a retail pharmacy.	S	P	A/N	1	2643	2643	
232	COB PRIMARY PAYER ID	ID assigned to primary payer.	n/a	S	C/P	A/N	10	2644	2653	
	FILLER	n/a	n/a	S	P	A/N	8	2654	2661	
228	COB PRIMARY PAYER AMOUNT PAID	Amount paid by primary payer for product or service.	n/a	S	C/P	D	8	2662	2669	SCDHHS does NOT use this field.
231	COB PRIMARY PAYER DEDUCTIBLE	Deductible amount according to primary payer for product or service.	n/a	S	C/P	D	8	2670	2677	
229	COB PRIMARY PAYER COINSURANCE	Coinsurance amount according to primary payer for product or service.	n/a	S	C/P	D	8	2678	2685	
230	COB PRIMARY PAYER COPAY	Co-pay amount according to primary payer for product or service.	n/a	S	C/P	D	8	2686	2693	
238	COB SECONDARY PAYER ID	ID assigned to secondary payer.	n/a	S	C/P	A/N	10	2694	2703	
	FILLER	n/a	n/a	S	P	A/N	8	2704	2711	

234	COB SECONDARY PAYER AMOUNT PAID	Amount paid by secondary payer for product or service.	n/a	S	C/P	D	8	2712	2719	
237	COB SECONDARY PAYER DEDUCTIBLE	Deductible amount according to secondary payer for product or service.	n/a	S	C/P	D	8	2720	2727	
235	COB SECONDARY PAYER COINSURANCE	Coinsurance amount according to secondary payer for product or service.	n/a	S	C/P	D	8	2728	2735	
236	COB SECONDARY PAYER COPAY	Co-pay amount according to secondary payer for product or service.	n/a	S	C/P	D	8	2736	2743	
SECTION DENOTES REFERENCE CATEGORY:										
896	TRANSACTION ID	Internally assigned unique claim ID by the payer.	n/a	S	P	A/N	30	2744	2773	This field is mapped to bytes 1268-1283 of the flat file and at max can only be 16 bytes in length. The field 896 in the NCPDP allows for 30 bytes but if you put more than 16 bytes in this field the translator will truncate and only move the first 16 bytes into the MMIS field. SCDHHS uses this field to assign the encounter ID. You must always use a new and unique ID for each encounter in this field. How To Void A NCPDP Encounter: 1. Put the encounter ID of the original encounter (the one

										you wish to void) in bytes 3296 – 3312 of the detail record. This should be all 17 bytes of the encounter ID of the original. An 'E' will be in byte 3312. 2. Put a 'V' in byte 3313 of the header record. 3. Put a new, unique claim ID in bytes 2744 – 2761 . For voids most MCOs put a 'V' in front of the original encounter ID or at a 'V' at the end of the original encounter ID. For example if an MCO sent in an encounter with an ID = '123456789', then for the void put either 'V123456789' or '123456789V'.
503-F3	AUTHORIZATION NUMBER	Number assigned by the processor to identify an authorized transaction.	n/a	S	P	A/N	20	2774	2793	
224	CLIENT SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by client.	n/a	S	P	A/N	50	2794	2843	
396	PROCESSOR SPECIFIC DATA	Trading partners mutually agreed upon specific data defined by processor.	n/a	S	P	A/N	50	2844	2893	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.	Y- *Yes* = CMS qualified facility N- *No* = Not a CMS qualified facility	S	C	A/N	1	2894	2894	

SECTION DENOTES FIELDS ADDED IN VERSIONS CATEGORY:										
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Blank- *Not Specified* Ø1- *Deductible* – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2- *Initial Benefit* – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3- *Coverage Gap (donut hole)* – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. 04- *Catastrophic Coverage* – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 50- *Not paid under Part D, paid under Part C benefit (for MA-PD plan):* · This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. · The claim is NOT paid by the Part D plan benefit · The claim IS paid for by Part C benefit (MA portion of the MA-PD). · When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 60- *Not paid under Part D, paid as or under a supplemental benefit only:* · This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided. · This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). · The claim is NOT paid by the Part D plan benefit	S	C	A/N	2	2895	2896	

			but is paid under the supplemental benefit. · When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights". 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. *Note: Non-qualified drugs are defined as no meeting the definition of a Part D drug.* 61- *Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only*: · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. · When the qualifier value of 61is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62-Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is							

			provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. · When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. *Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.* 70- *Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.). · When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 80- *Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e. excluded drugs). · When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be							

			populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 90- *Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan*: · When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2897	2904	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Blank- *Not Specified* Ø1- *Deductible* – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2- *Initial Benefit* – The first monthly benefit, or the first monthly benefit following any break in participation. Ø3- *Coverage Gap (donut hole)* – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. 04- *Catastrophic Coverage* – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 50- *Not paid under Part D, paid under Part C benefit (for MA-PD plan):* · This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. · The claim is NOT paid by the Part D plan benefit · The claim IS paid for by Part C benefit (MA portion of the MA-PD). · When the qualifier value of 5Ø is used, the Benefit	S	C	A/N	2	2905	2906	

			Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 60- *Not paid under Part D, paid as or under a supplemental benefit only:* · This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided. · This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). · The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. · When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · Since 6Ø is not specific to a Part D covered drug versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights". 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. *Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.* 61- *Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only*: · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is							

			provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. · When the qualifier value of 61is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62-Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. · When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. *Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.* 70- *Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.). · When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the							

			claim. · For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 80- *Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e. excluded drugs). · When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 90- *Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan*: · When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2907	2914	
393-MV	BENEFIT STAGE QUALIFIER	Code qualifying the 'Benefit Stage Amount' (394-MW).	Blank- *Not Specified* Ø1- *Deductible* – The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Ø2- *Initial Benefit* – The first monthly benefit, or the first monthly benefit following any break in participation.	S	C	A/N	2	2915	2916	

			Ø3- *Coverage Gap (donut hole)* – Commonly referred to as the "donut hole." Amount paid for Medicare prescription drug coverage, with a PDP or an MA-PD, after the initial coverage limit and until the total out of your pocket paid for covered prescription drugs reaches a certain amount. 04- *Catastrophic Coverage* – Once a total maximum is reached, the insured pays a small amount for a drug claim until the end of the calendar year. 50- *Not paid under Part D, paid under Part C benefit (for MA-PD plan):* · This qualifier applies to MA-PD plans where the claim is submitted under the Part D BIN/PCN. · The claim is NOT paid by the Part D plan benefit · The claim IS paid for by Part C benefit (MA portion of the MA-PD). · When the qualifier value of 5Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 60- *Not paid under Part D, paid as or under a supplemental benefit only:* · This qualifier applies to co-administered plans, where the claim is submitted under the part D BIN/PCN and where one pharmacy response is provided. · This qualifier also applies to Primary claims submitted under the Part D BIN/PCN when a supplemental benefit is provided (drugs covered outside of the allowable Part D benefit). · The claim is NOT paid by the Part D plan benefit but is paid under the supplemental benefit. · When the qualifier value of 6Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · Since 6Ø is not specific to a Part D covered drug							

			versus a non-Part D drug/non-qualified either of the following situations may occur: 1. For Part D drugs not paid by the Part D plan benefit, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights". 2. For non-Part D/non-qualified drugs Benefit Stage Qualifier 6Ø will be returned without the Approved Message Code value of Ø18. *Note: Non-qualified drugs are defined as no meeting the definition of a Part D drug.* 61- *Part D drug not paid by Part D plan benefit, paid as or under a co-administered insured benefit only*: · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered insured benefit. · When the qualifier value of 61is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 62-Non-Part D/non-qualified drug not paid by Part D plan benefit. Paid as or under a co-administered benefit only · This qualifier applies to co-administered plans, where the claim is submitted under the Part D BIN/PCN and where one pharmacy response is provided. · The claim is NOT paid by the Part D plan benefit but is paid under the co-administered benefit. · When the qualifier value of 62 is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MC Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the							

			claim. *Note: Non-qualified drugs are defined as not meeting the definition of a Part D drug.* 70- *Part D drug not paid by Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when the Part D drug is not covered by the plan (e.g. non-formulary, quantity limit, etc.). · When the qualifier value of 7Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. · For Part D drugs not paid by the Part D plan benefit, paid by the beneficiary under plan-sponsored negotiated pricing, the Approved Message Code field (548-6F) must be returned with a value Ø18 – "Provide Notice: Medicare Prescription Drug Coverage and Your Rights." 80- *Non-Part D/non-qualified drug not paid by Part D plan benefit, hospice benefit, or any other component of Medicare; paid by the beneficiary under plan-sponsored negotiated pricing*: · This qualifier applies to a plan sponsor that offers negotiated pricing to the beneficiary when drug is not covered under Part D law (i.e. excluded drugs). · When the qualifier value of 8Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used. · The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim. 90- *Enhance or OTC drug (PDE value of E/O) not applicable to the Part D drug spend, but is covered by the Part D plan*: · When the qualifier value of 9Ø is used, the Benefit Stage Count is 1 and no other benefit stage qualifier should be used.							

			· The field 394-MV Benefit Stage Amount should be populated with the total amount (total of 5Ø5-F5 Patient Pay Amount, 5Ø9-F9 Total Amount Paid, and 566-J5 Other Payer Amount Recognized) of the claim.							
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2917	2924	
393-MV	BENEFIT STAGE QUALIFIER	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	A/N	2	2925	2926	
394-MW	BENEFIT STAGE AMOUNT	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	n/a	S	C	D	8	2927	2934	
690-ZG	INVOICED DATE	The date this claim was included on an invoice.	n/a	S	P	N	8	2935	2942	
691-ZH	OUT OF POCKET REMAINING AMOUNT	Dollars remaining until patient is totally in benefit paying no out of pocket expenses.	n/a	S	P	D	8	2943	2950	
302-C2	CARDHOLDER ID (ALTERNATE)	Insurance ID assigned to the cardholder or identification number used by the plan.	n/a	S	P	A/N	20	2951	2970	HMO Client ID number. SCDHHS does not use this field for any processing. This field's sole purpose is to tie the encounter back to something in the MCO's system. MAXIMUM 15 characters.
692-ZJ	NUMBER OF GENERIC MANUFACTURERS	Number of manufacturers that produce this generic	n/a	S	P	N	3	2971	2973	

		drug provided by drug compendium.								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	2974	2975	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	2976	2994	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	2995	2996	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	2997	3015	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3016	3017	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3018	3036	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3037	3038	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3039	3057	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3058	3059	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3060	3078	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3079	3080	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3081	3099	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3100	3101	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3102	3120	

		drug or prompting pharmacist professional service).								
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	3121	3122	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed	n/a	S	C	A/N	19	3123	3141	

		drug or prompting pharmacist professional service).								
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.*	S	C	A/N	2	3142	3143	

			11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3144	3153	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the	S	C	A/N	2	3154	3155	

			patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3156	3165	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer.	S	C	A/N	2	3166	3167	

			Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3168	3177	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar	S	C	A/N	2	3178	3179	

			value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3180	3189	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability.	S	C	A/N	2	3190	3191	

			Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							

352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3192	3201	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.*	S	C	A/N	2	3202	3203	

			11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3204	3213	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the	S	C	A/N	2	3214	3215	

			patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3216	3225	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer.	S	C	A/N	2	3226	3227	

			Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3228	3237	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription.	S	C	A/N	2	3238	3239	

			Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3240	3249	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	Blank- *Not Specified* Ø1- *Amount Applied to Periodic Deductible (517-FH) as reported by previous payer.* The following dollar amount is the amount of the patient's responsibility	S	C	A/N	2	3250	3251	

			applied to the patient's plan periodic deductible liability. Ø2- *Amount Attributed to Product Selection/Brand Drug (134-UK) as reported by previous payer.* Ø3- *Amount Attributed to Sales Tax (523-FN) as reported by previous payer*. A dollar value of the portion of the copay (as reported by previous payer) which the member is required to pay due to sales tax on the prescription. Ø4- *Amount Exceeding Periodic Benefit Maximum (52Ø-FK) as reported by previous payer*. A dollar value of the portion of the copay which the member is required to pay due to a benefit cap/maximum being met or exceeded. Ø5- *Amount of Copay (518-FI) as reported by previous payer.* Code indicating that the following dollar amount is the amount of the patient responsibility applied to the patient's plan co-pay liability by another/previous payer. Ø6- *Patient Pay Amount (5Ø5-F5) as reported by previous payer*. Used to indicate the provider is submitting the amount reported by a prior payer as the patient's responsibility. Ø7- *Amount of Coinsurance (572-4U) as reported by previous payer.* Coinsurance is a form of cost sharing that holds the patient responsible for a dollar amount based on a percentage for each product/service received and regardless of the patient's current benefit status, product selection or network selection. Ø8- *Amount Attributed to Product Selection/Non-Preferred Formulary Selection (135-UM) as reported by previous payer*. Ø9- *Amount Attributed to Health Plan Assistance Amount (129-UD) as reported by previous payer*. 1Ø- *Amount Attributed to Provider Network Selection (133-UJ) as reported by previous payer.* 11- *Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection (136-UN) as reported by previous payer.* 12- *Amount Attributed to Coverage Gap (137-UP) that was to be collected from the patient due to a coverage gap as reported by previous payer.* 13- *Amount Attributed to Processor Fee (571-NZ) as reported by previous payer.*							

352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	The patient's cost share from a previous payer.	n/a	S	C	D	10	3252	3261	
A37	SPECIALTY CLAIM INDICATOR	Indicates whether a claim was filled by a specialty pharmacy or a specialty drug.	Blank- *Default* 1- *Specialty claim*. 2- *Not a specialty claim*	S	P	A/N	1	3262	3262	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3263	3265	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3266	3268	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3269	3271	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3272	3274	
A38	MEMBER SUBMITTED CLAIM REJECT CODE	For member submitted claims; a processor-specified list.	n/a	S	P	A/N	3	3275	3277	
A39	COPAY WAIVER AMOUNT	Dollar amount funded by third party for a copay waiver program where a client funds a portion of their copay amount if they select a certain drug.	n/a	S	P	D	8	3278	3285	
A33-ZX	CMS PART D CONTRACT ID	Designation assigned by CMS that identifies a specific Medicare Part D sponsor.	n/a	S	P	A/N	5	3286	3290	
A34-ZY	MEDICARE PART D PLAN BENEFIT PACKAGE (PBP)	Identifier assigned by CMS of a particular plan benefit package (Benefit Category) within a Medicare Part D contract.	n/a	S	P	N	3	3291	3293	
A73	MEDICARE DRUG COVERAGE CODE	Code to indicate if the claim was processed under the Part D Drug Benefit, the Part B	ØØ- *Does Not Apply* – Used when other values do not apply.	S	P	A/N	2	3294	3295	

		Drug Benefit, or does not apply.	Ø1- *Processed Under Part D* – A product that is processed under the Medicare Part D benefit which includes covered, enhanced, and OTC. Ø2- *Processed Under Part B* – A product that is processed under the Medicare Part B benefit							
	ORIGINAL TRANSACTION ID	Internally assigned unique encounter ID, being voided, by the payer.	n/a	S	P	A/N	17	3296	3312	How To Void A NCPDP Encounter: 1. Put the encounter ID of the original encounter (the one you wish to void) in bytes 3296 – 3312 of the detail record. This should be all 17 bytes of the encounter ID of the original. An 'E' will be in byte 3312. 2. Put a 'V' in byte 3313 of the header record. 3. Put a new, unique claim ID in bytes 2744 – 2761 . For voids most MCOs put a 'V' in front of the original encounter ID or at a 'V' at the end of the original encounter ID. For example if an MCO sent in an encounter with an ID = '123456789', then for the void put either 'V123456789' or '123456789V'.
	VOIDED TRANSACTION IDENTIFIER	Put a "V" in byte 110 to identify a voided encounter.	**V – Voided Encounter**	S	P	A/N	1	3313	3313	How To Void A NCPDP Encounter: 1. Put the encounter ID of the original

										encounter (the one you wish to void) in bytes 3296 – 3312 of the detail record. This should be all 17 bytes of the encounter ID of the original. An 'E' will be in byte 3312. 2. Put a 'V' in byte 3313 of the header record. 3. Put a new, unique claim ID in bytes 2744 – 2761 . For voids most MCOs put a 'V' in front of the original encounter ID or at a 'V' at the end of the original encounter ID. For example if an MCO sent in an encounter with an ID = '123456789', then for the void put either 'V123456789' or '123456789V'.
	FILLER	n/a	n/a	M	P	A/N	405	3314	3700	

8.2.1 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD1

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	SCDHHS Requirement
601-04	RECORD TYPE	Type of record being submitted.	CD- *Post Adjudication History Compound Detail Record1* CE- *Post Adjudication History Compound Detail Record2* DE- *Post Adjudication History Detail Record*	M	P	A/N	2	1	2	

			PA- *Post Adjudication History Header Record* PT- *Post Adjudication History Trailer Record*							
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	Prescription/ Service Reference Number Qualifier	1- Rx Billing Transaction- A billing for a prescription or OTC drug product 2- *Service Billing* – Transaction is a billing for a professional service performed.	M	C	A/N	1	3	3	
402-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	n/a	M	C	N	12	4	15	
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	M	C	N	2	16	17	
SECTION DENOTES FIRST INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	M	C	A/N	2	18	19	
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	M	C	A/N	19	20	38	If a compound drug is being reported, this is the NDC of the FIRST

										component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	39	52	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	53	60	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing.	S	C	A/N	2	61	62	

			Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	63	63	Indicates the NDC for the FIRST component of the compound drug is not recognized by SCDHHS but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	64	93	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	94	123	
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	124	133	

243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	134	137	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- First DataBank – A drug database company 2- Medi-Span Product Line – A drug database company 3- Micromedex/Medical Economics – A drug database company 4- *Processor Developed* – A proprietary drug file 5- *Other* – Different from those implied or specified 6- *Redbook* – A Micromedex publication of drug information 7- *Multum* – Drug database company	S	P	A/N	1	138	138	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	139	139	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of	S	P	A/N	1	140	140	

			products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	141	141	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- *Schedule II Narcotic Substances* 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	142	142	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	143	143	

601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* 1 *American Hospital Formulary Service (AHFS) Code* – Suite of products providing peer-reviewed information on medicines	S	P	A/N	1	144	144	

			and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.						

601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	145	161	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	162	162	

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	163	179	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions.	S	P	A/N	1	180	180	

		in the Product Code (6Ø1-18) field.	1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations;							

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601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	181	197	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	198	198	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient	S	P	A/N	1	199	199	

			combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications.							

			C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	200	216	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution.	S	P	A/N	1	217	217	

			2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO.							

			G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	218	234	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	S	P	A/N	1	235	235	

			3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting							

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601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	236	252	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to	S	P	A/N	1	253	253	

			characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC*							

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601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	254	270	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use.	S	C	N	1	271	271	

			Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	272	273	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- Not Specified 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction.	S	P	N	2	274	275	

			7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	276	276	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	277	278	

475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	279	280	
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	281	299	

260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	300	300	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	301	301	
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	302	309	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	310	318	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	319	327	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	328	336	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	337	345	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	346	354	

522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	355	356	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. 08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL 00 = 'Z' which is for Zero billed/Provider did not charge
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	357	364	
SECTION DENOTES SECOND INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	365	366	
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	367	385	If a compound drug is being reported, this is the NDC of the SECOND component of the compound drug.

448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	386	399	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	400	407	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by	S	C	A/N	2	408	409	

			Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- Cost basis on un-reportable quantities							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified* Y- *Yes* N- *No*	S	P	A/N	1	410	410	Indicates the NDC for the SECOND component of the compound drug is not recognized by SCDHHS but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	411	440	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	441	470	
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	471	480	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	481	484	

532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	485	485	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	486	486	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of	S	P	A/N	1	487	487	

			products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	488	488	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	489	489	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	490	490	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient	S	P	A/N	1	491	491	

			combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications.							

			C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	492	508	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution.	S	P	A/N	1	509	509	

			2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO.							

			G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	510	526	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	S	P	A/N	1	527	527	

			3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting							

			Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	528	544	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	545	545	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific	S	P	A/N	1	546	546	

			therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g.							

			manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	547	563	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	564	564	

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	565	581	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration.	S	P	A/N	1	582	582	

			7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are							

			traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	583	599	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form.	S	P	A/N	1	600	600	

			8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type							

			Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	601	617	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	618	618	
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	619	620	
299	PROCESSOR DEFINED PRIOR	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization*	S	P	N	2	621	622	

	AUTHORIZATION REASON CODE		a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes.							

			9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	623	623	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	624	625	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI	S	C	A/N	2	626	627	

			12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	628	646	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	647	647	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B	S	P	A/N	1	648	648	

			2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	649	656	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	657	665	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	666	674	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	675	683	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	684	692	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	693	701	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	702	703	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator.

										08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL 00 = 'Z' which is for Zero billed/Provider did not charge
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	704	711	
SECTION DENOTES THIRD INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	712	713	
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	714	732	If a compound drug is being reported, this is the NDC of the THIRD component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	733	746	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.

449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	747	754	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified.	S	C	A/N	2	755	756	

			1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- Cost basis on un-reportable quantities							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified* Y- *Yes* N- *No*	S	P	A/N	1	757	757	Indicates the NDC for the THIRD component of the compound drug is not recognized by SCDHHS but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	758	787	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	788	817	
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	818	827	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	828	831	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information	S	P	A/N	1	832	832	

			7- *Multum* - Drug database company							
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	2 *Not specified* 3 *Single Source* – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	833	833	
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.	S	P	A/N	1	834	834	

			P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	835	835	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	836	836	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	837	837	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for	S	P	A/N	1	838	838	

			online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard							

			layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	839	855	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active	S	P	A/N	1	856	856	

			ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)*							

			M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	857	873	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified.	S	P	A/N	1	874	874	

			4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid							

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601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	875	891	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	892	892	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to	S	P	A/N	1	893	893	

			characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC*							

			O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	894	910	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	911	911	

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*						

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601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	912	928	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	929	929	

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	930	946	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	947	947	

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.						

601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	948	964	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	965	965	
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	966	967	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting	S	P	N	2	968	969	

			the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	970	970	

		(Maximum Allowable Cost) program.								
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	971	972	
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID	S	C	A/N	2	973	974	

			18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	975	993	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	994	994	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check	S	P	A/N	1	995	995	

			D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	996	1003	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1004	1012	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1013	1021	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1022	1030	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1031	1039	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1040	1048	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1049	1050	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. 08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL

										00 = 'Z' which is for Zero billed/Provider did not charge
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1051	1058	
SECTION DENOTES FOURTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	1059	1060	
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1061	1079	If a compound drug is being reported, this is the NDC of the FOURTH component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1080	1093	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient	n/a	S	C	D	8	1094	1101	

		Quantity' (Field 448-ED).								
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates,	S	C	A/N	2	1102	1103	

			and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified*. Y- *Yes* N- *No*	S	P	A/N	1	1104	1104	Indicates the NDC for the FOURTH component of the compound drug is not recognized by SCDHHS but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1105	1134	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1135	1164	
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1165	1174	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1175	1178	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1179	1179	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer	S	P	N	1	1180	1180	

			of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and	S	P	A/N	1	1181	1181	

			the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1182	1182	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1183	1183	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1184	1184	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific	S	P	A/N	1	1185	1185	

			therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g.							

			manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1186	1202	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	1203	1203	

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1204	1220	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration.	S	P	A/N	1	1221	1221	

			7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are							

			traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1222	1238	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	1239	1239	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	1240	1240	

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1241	1257	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	1258	1258	

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							

601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1259	1275	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	1276	1276	

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1277	1293	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions.	S	P	A/N	1	1294	1294	

		'Therapeutic Class Code' (6Ø1-25) field.	1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations;							

			chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1295	1311	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use	S	C	N	1	1312	1312	

			package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1313	1314	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment.	S	P	N	2	1315	1316	

			3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1317	1317	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed.	S	P	A/N	2	1318	1319	

			Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID	S	C	A/N	2	1320	1321	

			30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1322	1340	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1341	1341	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	1342	1342	
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter;	n/a	S	P	A/N	8	1343	1350	

		from formulary file as defined by processor								
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1351	1359	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1360	1368	
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1369	1377	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1378	1386	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1387	1395	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1396	1397	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. 08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL 00 = 'Z' which is for Zero billed/Provider did not charge
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1398	1405	

SECTION DENOTES FIFTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	1406	1407	
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1408	1426	If a compound drug is being reported, this is the NDC of the FIFTH component of the compound drug.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1427	1440	Amount expressed in metric decimal units of the product included in the compound mixture. MASK 9(7)V999 zero filled, no sign.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	1441	1448	
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs.	S	C	A/N	2	1449	1450	

		compound was calculated	Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient.							

			14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	1451	1451	Indicates the NDC for the FIFTH component of the compound drug is not recognized by SCDHHS but the MCO covered the drug. Value 'Y'
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1452	1481	
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1482	1511	
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1512	1521	
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1522	1525	
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1526	1526	
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on	S	P	N	1	1527	1527	

			the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.	S	P	A/N	1	1528	1528	

244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1529	1529	
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1530	1530	
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1531	1531	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	1532	1532	

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1533	1549	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration.	S	P	A/N	1	1550	1550	

			7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are							

			traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1551	1567	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form.	S	P	A/N	1	1568	1568	

			8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type							

			Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1569	1585	
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- Not specified 1- *Yes* 2- *No*	S	P	A/N	1	1586	1586	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the	S	P	A/N	1	1587	1587	

			unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							

601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1588	1604	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	1605	1605	

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1606	1622	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions.	S	P	A/N	1	1623	1623	

		'Therapeutic Class Code' (6Ø1-25) field.	1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations;							

			chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1624	1640	
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for	S	P	A/N	1	1641	1641	

			online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard							

			layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1642	1658	
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly.	S	C	N	1	1659	1659	

			5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1660	1661	
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required.	S	P	N	2	1662	1663	

			4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1664	1664	
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication.	S	P	A/N	2	1665	1666	

			Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD	S	C	A/N	2	1667	1668	

			40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1669	1687	
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1688	1688	
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	1689	1689	
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	1690	1697	
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1698	1706	
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1707	1715	

211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1716	1724	
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1725	1733	
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1734	1742	
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1743	1744	Translator will have to crosswalk the four values below to a 'C', 'F', 'T' or 'Z' to put in the flat file created by the translator. 08 = 'C' which is for capitated 01 = 'F' which is for FFS 14 = 'T' which is TPL 00 = 'Z' which is for Zero billed/Provider did not charge
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1745	1752	
SECTION DENOTES SIXTH INGREDIENT:						A/N	347	1753	2099	
SECTION DENOTES SEVENTH INGREDIENT:						A/N	347	2100	2446	
SECTION DENOTES EIGHTH INGREDIENT:						A/N	347	2447	2793	

	FILLER	n/a	n/a	M	P	A/N	907	2794	3700	

8.2.2 POST ADJUDICATION HISTORY COMPOUND DETAIL RECORD2

SCDHHS only accepts Compound Detail Record1.
DO NOT SEND Compound Detail Record2

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	SCDHHS Requirement
601-04	RECORD TYPE	Type of record being submitted.	CD- *Post Adjudication History Compound Detail Record1* CE- *Post Adjudication History Compound Detail Record2* DE- *Post Adjudication History Detail Record* PA- *Post Adjudication History Header Record* PT- *Post Adjudication History Trailer Record*	M	P	A/N	2	1	2	SCDHHS does not accept.
455-EM	PRESCRIPTIONSERVICE REFERENCE NUMBER QUALIFIER	Prescription/ Service Reference Number Qualifier	1- Rx Billing Transaction- A billing for a prescription or OTC drug product 2- *Service Billing* – Transaction is a billing for a professional service performed.	M	C	A/N	1	3	3	SCDHHS does not accept.
402-D2	PRESCRIPTIONSERVICE REFERENCE NUMBER	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	n/a	M	C	N	12	4	15	SCDHHS does not accept.
477-EC	COMPOUND INGREDIENT COMPONENT COUNT	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	M	C	N	2	16	17	SCDHHS does not accept.
SECTION DENOTES NINTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC	M	C	A/N	2	18	19	SCDHHS does not accept.

			04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	M	C	A/N	19	20	38	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	39	52	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	53	60	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs.	S	C	A/N	2	61	62	SCDHHS does not accept.

			Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	63	63	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	64	93	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	94	123	SCDHHS does not accept.

601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	124	133	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	134	137	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	138	138	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	139	139	SCDHHS does not accept.
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.	S	P	A/N	1	140	140	SCDHHS does not accept.

			K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	141	141	SCDHHS does not accept.
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	142	142	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	143	143	SCDHHS does not accept.

		Food and Drug Administration.								
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	144	144	SCDHHS does not accept.

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	145	161	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions.	S	P	A/N	1	162	162	SCDHHS does not accept.

		in the Product Code (6Ø1-18) field.	1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations;							

			chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	163	179	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for	S	P	A/N	1	180	180	SCDHHS does not accept.

			online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard						

			layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	181	197	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	198	198	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution.	S	P	A/N	1	199	199	SCDHHS does not accept.

			2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO.							

			G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	200	216	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	S	P	A/N	1	217	217	SCDHHS does not accept.

			3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting							

			Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	218	234	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to	S	P	A/N	1	235	235	SCDHHS does not accept.

			characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC*							

			O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	236	252	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	253	253	SCDHHS does not accept.

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*						

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	254	270	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	271	271	SCDHHS does not accept.

600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	272	273	SCDHHS does not accept.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states	S	P	N	2	274	275	SCDHHS does not accept.

			the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	276	276	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	277	278	SCDHHS does not accept.
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC	S	C	A/N	2	279	280	SCDHHS does not accept.

			06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	281	299	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	300	300	SCDHHS does not accept.

292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	301	301	SCDHHS does not accept.
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	302	309	SCDHHS does not accept.
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	310	318	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	319	327	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	328	336	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	337	345	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	346	354	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item.	S	C	N	2	355	356	SCDHHS does not accept.

		'Ingredient Cost Paid' (5Ø6-F6).	8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).							
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	357	364	SCDHHS does not accept.
SECTION DENOTES TENTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	365	366	SCDHHS does not accept.
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	367	385	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	386	399	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	400	407	SCDHHS does not accept.

490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- Default Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer.	S	C	A/N	2	408	409	SCDHHS does not accept.

			12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	410	410	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	411	440	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	441	470	SCDHHS does not accept.
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	471	480	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	481	484	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	485	485	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA).	S	P	N	1	486	486	SCDHHS does not accept.

			4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.	S	P	A/N	1	487	487	SCDHHS does not accept.
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug	n/a	S	P	A/N	1	488	488	SCDHHS does not accept.

		category code is associated with a specific drug category.								
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	489	489	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	490	490	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	491	491	

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*							

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	492	508	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	509	509	SCDHHS does not accept.

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	510	526	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	527	527	SCDHHS does not accept.

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.						

601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	528	544	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	545	545	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure.	S	P	A/N	1	546	546	SCDHHS does not accept.

			9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	547	563	SCDHHS does not accept.

601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and	S	P	A/N	1	564	564	SCDHHS does not accept.

			toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	565	581	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form,	S	P	A/N	1	582	582	SCDHHS does not accept.

			and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to							

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601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	583	599	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically	S	P	A/N	1	600	600	SCDHHS does not accept.

			equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)*							

			H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	601	617	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration.	S	C	N	1	618	618	SCDHHS does not accept.

			6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	619	620	SCDHHS does not accept.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay	S	P	N	2	621	622	SCDHHS does not accept.

			and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	623	623	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing.	S	P	A/N	2	624	625	

			Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	626	627	SCDHHS does not accept.

476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	628	646	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	647	647	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	648	648	SCDHHS does not accept.
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	649	656	SCDHHS does not accept.
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	657	665	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	666	674	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	675	683	SCDHHS does not accept.

253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	684	692	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	693	701	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	702	703	SCDHHS does not accept.
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	704	711	SCDHHS does not accept.
SECTION DENOTES ELEVENTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	712	713	SCDHHS does not accept.
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	714	732	SCDHHS does not accept.

448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	733	746	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	747	754	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)).	S	C	A/N	2	755	756	SCDHHS does not accept.

			Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	757	757	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	758	787	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	788	817	SCDHHS does not accept.
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	818	827	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	828	831	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	832	832	SCDHHS does not accept.

425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	833	833	**SCDHHS does not accept.**
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary.	S	P	A/N	1	834	834	SCDHHS does not accept.

			T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	835	835	SCDHHS does not accept.
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	836	836	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	837	837	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active	S	P	A/N	1	838	838	SCDHHS does not accept.

			ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)*							

			M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	839	855	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified.	S	P	A/N	1	856	856	SCDHHS does not accept.

			4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid							

			by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	857	873	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	874	874	SCDHHS does not accept.

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	875	891	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	892	892	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	893	893	SCDHHS does not accept.

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*						

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	894	910	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	911	911	SCDHHS does not accept.

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	912	928	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	929	929	SCDHHS does not accept.

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.						

601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	930	946	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	947	947	SCDHHS does not accept.

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	948	964	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging.	S	C	N	1	965	965	SCDHHS does not accept.

			2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	966	967	SCDHHS does not accept.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an	S	P	N	2	968	969	SCDHHS does not accept.

			incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	970	970	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed.	S	P	A/N	2	971	972	SCDHHS does not accept.

		based on client pricing.	Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS	S	C	A/N	2	973	974	SCDHHS does not accept.

			28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	975	993	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	994	994	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	995	995	SCDHHS does not accept.
889	THERAPEUTIC CHAPTER	An eight position field representing the	n/a	S	P	A/N	8	996	1003	SCDHHS does not accept.

		therapeutic chapter; from formulary file as defined by processor								
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1004	1012	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1013	1021	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1022	1030	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1031	1039	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1040	1048	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1049	1050	SCDHHS does not accept.
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1051	1058	SCDHHS does not accept.
SECTION DENOTES TWELVTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI	S	C	A/N	2	1059	1060	SCDHHS does not accept.

			12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1061	1079	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1080	1093	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	1094	1101	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs.	S	C	A/N	2	1102	1103	SCDHHS does not accept.

			Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	1104	1104	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1105	1134	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1135	1164	SCDHHS does not accept.

601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1165	1174	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1175	1178	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1179	1179	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	1180	1180	SCDHHS does not accept.
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.	S	P	A/N	1	1181	1181	SCDHHS does not accept.

			K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1182	1182	SCDHHS does not accept.
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1183	1183	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1184	1184	SCDHHS does not accept.

601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and	S	P	A/N	1	1185	1185	SCDHHS does not accept.

			toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1186	1202	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form,	S	P	A/N	1	1203	1203	SCDHHS does not accept.

			and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to							

			describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1204	1220	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically	S	P	A/N	1	1221	1221	SCDHHS does not accept.

			equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)*							

			H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1222	1238	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	1239	1239	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active	S	P	A/N	1	1240	1240	SCDHHS does not accept.

			ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)*							

			M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1241	1257	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified.	S	P	A/N	1	1258	1258	SCDHHS does not accept.

			4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid							

			by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1259	1275	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	1276	1276	SCDHHS does not accept.

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1277	1293	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration.	S	P	A/N	1	1294	1294	SCDHHS does not accept.

			7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are							

			traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1295	1311	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	1312	1312	SCDHHS does not accept.
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1313	1314	SCDHHS does not accept.

299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the	S	P	N	2	1315	1316	SCDHHS does not accept.

			purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1317	1317	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	1318	1319	SCDHHS does not accept.
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS	S	C	A/N	2	1320	1321	SCDHHS does not accept.

			11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1322	1340	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1341	1341	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B	S	P	A/N	1	1342	1342	SCDHHS does not accept.

			2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	1343	1350	SCDHHS does not accept.
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1351	1359	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1360	1368	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1369	1377	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1378	1386	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1387	1395	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1396	1397	SCDHHS does not accept.

285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1398	1405	SCDHHS does not accept.
SECTION DENOTES THIRTEENTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	1059	1060	SCDHHS does not accept.
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1061	1079	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1080	1093	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	1094	1101	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a	*ØØ- Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs.	S	C	A/N	2	1102	1103	SCDHHS does not accept.

		compound was calculated	Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient.							

			14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	1104	1104	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1105	1134	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1135	1164	SCDHHS does not accept.
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1165	1174	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1175	1178	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1179	1179	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution:	S	P	N	1	1180	1180	SCDHHS does not accept.

			Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.	S	P	A/N	1	1181	1181	SCDHHS does not accept.
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1182	1182	SCDHHS does not accept.

252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1183	1183	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1184	1184	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	1185	1185	SCDHHS does not accept.

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1186	1202	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	1203	1203	SCDHHS does not accept.

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							

601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1204	1220	
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	1221	1221	SCDHHS does not accept.

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1222	1238	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	1239	1239	SCDHHS does not accept.

601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and	S	P	A/N	1	1240	1240	

			toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1241	1257	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form,	S	P	A/N	1	1258	1258	SCDHHS does not accept.

			and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to							

			describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1259	1275	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution.	S	P	A/N	1	1276	1276	SCDHHS does not accept.

			2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO.							

			G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1277	1293	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	S	P	A/N	1	1294	1294	SCDHHS does not accept.

			3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting							

			Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1295	1311	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with	S	C	N	1	1312	1312	SCDHHS does not accept.

			packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1313	1314	SCDHHS does not accept.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an	S	P	N	2	1315	1316	SCDHHS does not accept.

			exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1317	1317	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- Not Specified Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug.	S	P	A/N	2	1318	1319	SCDHHS does not accept.

			1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other	S	C	A/N	2	1320	1321	SCDHHS does not accept.
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting	n/a	S	C	A/N	19	1322	1340	SCDHHS does not accept.

		with the prescribed drug or prompting pharmacist professional service).								
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1341	1341	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	1342	1342	SCDHHS does not accept.
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	1343	1350	SCDHHS does not accept.
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1351	1359	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1360	1368	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1369	1377	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1378	1386	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable	n/a	S	P	D	9	1387	1395	SCDHHS does not accept.

		cost price for the product/service as defined by the processor.								
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1396	1397	SCDHHS does not accept.
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1398	1405	SCDHHS does not accept.
SECTION DENOTES FOURTEENTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI 12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other	S	C	A/N	2	1059	1060	SCDHHS does not accept.
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1061	1079	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1080	1093	SCDHHS does not accept.

449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	1094	1101	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	*ØØ- Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs. Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified.	S	C	A/N	2	1102	1103	SCDHHS does not accept.

			1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	1104	1104	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1105	1134	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1135	1164	SCDHHS does not accept.
601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1165	1174	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1175	1178	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1179	1179	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor.	S	P	N	1	1180	1180	SCDHHS does not accept.

			2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is							
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category. K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the	S	P	A/N	1	1181	1181	SCDHHS does not accept.

			list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1182	1182	SCDHHS does not accept.
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1183	1183	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1184	1184	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration.	S	P	A/N	1	1185	1185	

			3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting							

			Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1186	1202	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to	S	P	A/N	1	1203	1203	SCDHHS does not accept.

			characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC*							

			O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1204	1220	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	1221	1221	SCDHHS does not accept.

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*							

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1222	1238	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	1239	1239	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name.	S	P	A/N	1	1240	1240	SCDHHS does not accept.

			6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)*							

			U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1241	1257	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* –	S	P	A/N	1	1258	1258	SCDHHS does not accept.

			Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated.							

			V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1259	1275	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name,	S	P	A/N	1	1276	1276	SCDHHS does not accept.

			route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.						

601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1277	1293	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed	S	P	A/N	1	1294	1294	SCDHHS does not accept.

			information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1295	1311	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging.	S	C	N	1	1312	1312	

			2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was "loaded" at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer's package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).							
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1313	1314	SCDHHS does not accept.
299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an	S	P	N	2	1315	1316	SCDHHS does not accept.

			incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1317	1317	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed.	S	P	A/N	2	1318	1319	SCDHHS does not accept.

		based on client pricing.	Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.							
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS 11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS	S	C	A/N	2	1320	1321	SCDHHS does not accept.

			28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1322	1340	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1341	1341	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B 2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity	S	P	A/N	1	1342	1342	SCDHHS does not accept.
889	THERAPEUTIC CHAPTER	An eight position field representing the	n/a	S	P	A/N	8	1343	1350	SCDHHS does not accept.

		therapeutic chapter; from formulary file as defined by processor								
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1351	1359	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1360	1368	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1369	1377	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1378	1386	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1387	1395	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1396	1397	SCDHHS does not accept.
285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1398	1405	SCDHHS does not accept.
SECTION DENOTES FIFTEENTH INGREDIENT:										
488-RE	COMPOUND PRODUCT ID QUALIFIER	Code qualifying the type of product dispensed.	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 11- NAPPI	S	C	A/N	2	1059	1060	SCDHHS does not accept.

			12- GTIN 15- GCN 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 99- Other							
489-TE	COMPOUND PRODUCT ID	Product identification of an ingredient used in a compound.	n/a	S	C	A/N	19	1061	1079	SCDHHS does not accept.
448-ED	COMPOUND INGREDIENT QUANTITY	Amount expressed in metric decimal units of the product included in the compound mixture.	n/a	S	C	N	14	1080	1093	SCDHHS does not accept.
449-EE	COMPOUND INGREDIENT DRUG COST	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	n/a	S	C	D	8	1094	1101	SCDHHS does not accept.
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated	ØØ- *Default* Ø1- *AWP (Average Wholesale Price)* – A pricing benchmark for prescription drugs. Ø2- *Local Wholesaler* – A legitimate supplier from the surrounding area who resells drugs. Ø3- *Direct* – Represents the manufacturer's published catalog or list price for any item to non-wholesalers. It does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions. Ø4 –*EAC (Estimated Acquisition Cost)* – A formula-driven estimate of an entity's actual acquisition cost of a product, typically using as a percentage of AWP, derived by applying a discount to AWP. Various EAC methodologies may exist to estimate acquisition costs.	S	C	A/N	2	1102	1103	SCDHHS does not accept.

			Ø5- *Acquisition* – Used to indicate the provided ingredient cost is the actual cost as paid by the provider to the supplier for the specific item. Ø6- *MAC (Maximum Allowable Cost)* – Maximum reimbursable ingredient cost amount according to a payer's price list. Ø7- *Usual & Customary* – The pharmacy's price for the medication for a cash paying person on the day of dispensing. Ø8- *34ØB /Disproportionate Share Pricing/Public Health Service* – Price available under Section 34ØB of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 34ØB (a)(1Ø) and those made through the Prime Vendor Program (Section 34ØB(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation. Ø9- *Other* – Different from those implied or specified. 1Ø- *ASP (Average Sales Price)* – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11- *AMP (Average Manufacturer Price)* – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12- *WAC (Wholesale Acquisition Cost)* – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 13- *Special Patient Pricing* – The cost calculated by the pharmacy for the drug for this special patient. 14- *Cost basis on un-reportable quantities*							
221	CLIENT FORMULARY FLAG	Indicates that client has a formulary.	Blank- *Not specified.* Y- *Yes* N- *No*	S	P	A/N	1	1104	1104	SCDHHS does not accept.
397	PRODUCT/SERVICE NAME	Product or Service Description or Product Label Name.	n/a	S	P	A/N	30	1105	1134	SCDHHS does not accept.
261	GENERIC NAME	Generic name of the product identified in Product/Service Name.	n/a	S	P	A/N	30	1135	1164	SCDHHS does not accept.

601-24	PRODUCT STRENGTH	The strength of the product.	n/a	S	P	A/N	10	1165	1174	SCDHHS does not accept.
243	DOSAGE FORM CODE	Dosage form code for product identified.	n/a	S	P	A/N	4	1175	1178	SCDHHS does not accept.
532-FW	DATABASE INDICATOR	Code identifying the source of drug information used for DUR processing or to define the database used for identifying the product.	1- *First DataBank* - A drug database company 2- *Medi-Span Product Line* - A drug database company 3- *Micromedex/Medical Economics* - A drug database company 4- *Processor Developed* - A proprietary drug file 5- *Other* - Different from those implied or specified 6- *Redbook* - A Micromedex publication of drug information 7- *Multum* - Drug database company	S	P	A/N	1	1179	1179	SCDHHS does not accept.
425-DP	DRUG TYPE	Code to indicate the type of drug dispensed.	0- Not specified 1- Single Source – A clinical formulation that is only available from a single distributor. 2- *Authorized Generic (aka "Branded Generic")* – The originating company is authorizing the manufacturer of the drug using their New Drug Application (NDA). Often introduced as patent protection for the original branded formulation when nearing expiration. E.g. Pfizer and its subsidiary Greenstone. 3- *Generic* – The pharmaceutically equivalent product of a branded product introduced by additional distributors after patient protection has expired on the brand product. Manufactured under an Abbreviated New Drug Application (ANDA). 4- *Over the Counter* – Drugs and other pharmaceuticals that may be purchased without a prescription. These products do not carry the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription." 5- *Multi-source Brand* – Product's clinical formulation is	S	P	N	1	1180	1180	SCDHHS does not accept.
257	FORMULARY STATUS	Indicates the Formulary status of the Drug.	Blank- *Not Specified* I- Drug on Formulary; Non-Preferred – The medication submitted on the claim is included in the list of products in that patient's plan formulary but there is a preferable product in the therapeutic category. J- *Drug not on Formulary; Non-Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and there is a more preferable product in the therapeutic category.	S	P	A/N	1	1181	1181	SCDHHS does not accept.

			K- *Drug not on Formulary; Preferred* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, but the product is still considered the preferable choice. N- *Drug not on Formulary; Neutral* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary, and the plan has no specific preference as to the drug's status. P- *Drug on Formulary* – The medication submitted on the claim is included in the list of products in that patient's plan formulary. Q- *Drug not on Formulary* – The medication submitted on the claim is NOT included in the list of products in that patient's plan formulary. T- *Drug on Formulary; Preferred* – Therapeutic interchange occurred on this claim – The medication submitted on the claim is included in the list of products in that patient's plan formulary and the plan has allowed the substitution of an equivalent product. Y- *Drug on Formulary; Neutral* – The medication submitted on the claim is included in the list of payable products in that patient's plan formulary, and the plan has no specific preference as to the drug's status.							
244	DRUG CATEGORY CODE	The drug category to which a specified drug belongs. Each drug category code is associated with a specific drug category.	n/a	S	P	A/N	1	1182	1182	SCDHHS does not accept.
252	FEDERAL DEA SCHEDULE	The controlled substance schedule as defined by the Drug Enforcement Administration.	Blank- *Not Specified* 1- *Schedule I Substance (no known use)* 2- Schedule II Narcotic Substances 3- *Schedule III Narcotic Substances* 4- *Schedule IV Substances* 5- *Schedule V Substances*	S	P	A/N	1	1183	1183	SCDHHS does not accept.
250	FDA DRUG EFFICACY CODE	A one-position field which marks a particular drug as being declared less than effective by the Food and Drug Administration.	Blank- *Not Specified* Ø- *Was Drug Efficacy Study Implementation (DESI)* – At One Time But No Longer 1- *Drug Efficacy Study Implementation (DESI) Drug*	S	P	A/N	1	1184	1184	SCDHHS does not accept.

601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and	S	P	A/N	1	1185	1185	SCDHHS does not accept.

			toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1186	1202	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form,	S	P	A/N	1	1203	1203	SCDHHS does not accept.

			and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to							

			describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type *Z- Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1204	1220	SCDHHS does not accept.
601-19	PRODUCT CODE QUALIFIER	Identifies the type of data being submitted in the Product Code (6Ø1-18) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically	S	P	A/N	1	1221	1221	SCDHHS does not accept.

			equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)*							

			H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-18	PRODUCT CODE	Code identifying the product being reported.	n/a	S	P	A/N	17	1222	1238	SCDHHS does not accept.
251	FEDERAL UPPER LIMIT INDICATOR	Indicates if a Federal Upper Limit exists for the drug.	Blank- *Not specified* 1- *Yes* 2- *No*	S	P	A/N	1	1239	1239	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active	S	P	A/N	1	1240	1240	SCDHHS does not accept.

			ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)*							

			M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1241	1257	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified.	S	P	A/N	1	1258	1258	SCDHHS does not accept.

			4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid							

			by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1259	1275	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug.	S	P	A/N	1	1276	1276	SCDHHS does not accept.

			5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration. 7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)*							

			T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1277	1293	SCDHHS does not accept.
601-26	THERAPEUTIC CLASS CODE QUALIFIER	Identifies type of data being submitted in the 'Therapeutic Class Code' (6Ø1-25) field.	Blank- *Not Specified* – BLANK not used in Manufacturer Rebates Standard for any 1-versions. 1- First DataBank Formulation ID (GCN) – A five character numeric indicator that represents the generic formulation; specific to generic ingredient combination, route of administration, dosage form, and drug strength. The GCN is the same across manufacturers and/or package sizes; useful for online computer applications, such as generic substitution. 2- *Medi-Span Product Line Generic Product Identifier (GPI)* – A group or groups of pharmaceutically equivalent drug products. Products having the same 14-digit GPI are identical with respect to active ingredient(s), dosage form, route of administration and strength or concentration. 3- *First DataBank GC3* – A three character alphanumeric indicator that identifies the specific therapeutic class in which the active ingredient is classified. 4- *Medi-Span Product Line Drug Descriptor ID (DDID)* – Index terms and phrases assigned to each record to characterize the substantive content of the original drug. 5- *First DataBank Medication Name Identifier (FDB Med Name ID)* – A permanent numeric identifier that represents a unique product or generic name. 6- *First DataBank Routed Medication Identifier (FDB Routed Med ID)* – Represents the product or generic name and route of administration.	S	P	A/N	1	1294	1294	

			7- *First Databank Routed Dosage Form Medication Identifier (FDB Routed Dosage Form Med ID)* – Represents the product or generic name, route of administration, and dosage form. 8- First DataBank Medication Identifier (FDB MedID) – A permanent numeric identifier that represents the unique combination of product or generic name, route of administration, dosage form, strength, and strength unit-of-measure. 9- *Nine-digit NDC* A- American Hospital Formulary Service (AHFS) Code – Suite of products providing peer-reviewed information on medicines and drug products, including off-label and labeled uses, drug interactions; adverse reactions; cautions and toxicity; therapeutic perspective; specific dosage and administration information; preparations; chemistry and stability; pharmacology and pharmacokinetics; contraindications. C- *Contracting Organization (PMO) Assigned Code* – Internal alphanumeric code used by a PMO to describe a Product Code or Therapeutic Class in a NCPDP manufacturer rebate flat file standard layout. This code is an internal number assigned by the PMO. G- *First Data Bank GCN Sequence Number (Mnemonic: GCN*SEQNO)* H- *First Data Bank HICL Sequence Number (Mnemonic: HICL*SEQNO)* M- *Manufacturer (PICO) Assigned Code* – Code assigned by Pharmaceutical Industry Contracting Organization (PICO). (Any organization contracting to pay rebates for pharmaceutical products (e.g. manufacturer, distributor, other). Rebates are paid by the PICO to Pharmacy Management Organizations (PMOs)) N- *Eleven-digit NDC* O- *UPC (OTCS)* P- *Product group (brand or generic name)* T- *First Data Bank Therapeutic Class Code, Specific (Mnemonic: GC3 alias HIC3)* U- *Universal System of Classification Code (USC)* – A standard classification used to differentiate drug products by the markets in which they are							

			traditionally sold. The USC is maintained by its copyright owner, IMS Health Incorporated. V- *All products used* – Represents all valid products regardless of type Z- *Mutually Agreed Upon Code*- A code mutually agreed upon by trading partners to identify a given data type element.							
601-25	THERAPEUTIC CLASS CODE	Code assigned to product being reported.	n/a	S	P	A/N	17	1295	1311	SCDHHS does not accept.
429-DT	SPECIAL PACKAGING INDICATOR	Code indicating the type of dispensing dose.	0- Not Specified 1- Not Unit Dose – Indicates the product is not being dispensed in special unit dose packaging. 2- *Manufacturer Unit Dose* – A code used to indicate a distinct dose as determined by the manufacturer. 3- *Pharmacy Unit Dose* – Used to indicate when the pharmacy has dispensed the drug in a unit of use package which was “loaded” at the pharmacy – not purchased from the manufacturer as a unit dose. 4- *Pharmacy Unit Dose Patient Compliance Packaging* – Unit dose blister, strip or other packaging designed in compliance-prompting formats that help people take their medications properly. 5- *Pharmacy Multi-drug Patient Compliance Packaging* – Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 6- *Remote Device Unit Dose* – Drug is dispensed at the facility, via a remote device, in a unit of use package. 7- *Remote Device Multi-drug Compliance* – Drug is dispensed at the facility, via a remote device, with packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration. 8- *Manufacturer Unit of Use Package (not unit dose)* – Drug is dispensed by pharmacy in original manufacturer’s package and relabeled for use. Applicable in long term care claims only (as defined in Telecommunication Editorial Document).	S	C	N	1	1312	1312	SCDHHS does not accept.
600-28	UNIT OF MEASURE	NCPDP standard product billing codes.	EA- *Each* – Being one or individual. GM- *Grams* – A metric unit of mass equal to one thousandth of a kilogram. ML- *Milliliters* – A metric measure of volume equal to one thousandth of a liter.	S	C	A/N	2	1313	1314	SCDHHS does not accept.

299	PROCESSOR DEFINED PRIOR AUTHORIZATION REASON CODE	Code clarifying the Prior Authorization Number.	0- *Not Specified* 1- *Prior Authorization* a) Code assigned for use with claim billing to allow processing of a claim which would otherwise reject based upon benefit or program design. b) Indicator to convey that coverage of the specified product is dependent upon the prescriber submitting the request (including required documentation) to the payer/plan or designated utilization management organization for approval/authorization prior to ordering/dispensing the product. 2- *Medical Certification* – A code indicating that a health care provider practitioner certifies to an incapacitation, examination, or treatment or to a period of disability while a patient was or is receiving professional treatment. 3- *EPSDT (Early Periodic Screening Diagnosis Treatment)* – Code indicating information about services involving preventative health measures for children, e.g., screening assessments, tests and their subsequent results and findings, immunization information, guidance and education given, and follow-up care required. 4- *Exemption from Copay and/or Coinsurance* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from copay and/or coinsurance payments according to the benefit design. 5- *Exemption from RX* – Code used to classify the reason for the prior authorization request as one used when the member has qualified for an exemption from limitations on the number of prescriptions covered by the program/plan in a specified period of time. 6- *Family Planning Indicator* – Code to indicate the drug prescribed is for management of reproduction. 7- *TANF (Temporary Assistance for Needy Familie*s) – An organization that provides assistance and work opportunities to needy families by granting states the federal funds and the flexibility to develop and implement their own welfare programs. 8- *Payer Defined Exemption* – Used to indicate the provider is submitting the prior authorization for the	S	P	N	2	1315	1316	SCDHHS does not accept.

			purpose of utilizing a payer defined exemption not covered by one of the other type codes. 9- *Emergency Preparedness* – Code used to override claim edits during an emergency situation.							
272	MAC REDUCED INDICATOR	Indicates if a claim payment was reduced due to a MAC (Maximum Allowable Cost) program.	Blank- *Not Specified* Y- *Reduced to MAC pricing* N- *Not reduced to MAC pricing*	S	P	A/N	1	1317	1317	SCDHHS does not accept.
223	CLIENT PRICING BASIS OF COST	Code indicating the method by which ingredient cost submitted is calculated based on client pricing.	Blank- *Not Specified* Ø1- *Average Wholesale Price* – The current average wholesale price as listed in a nationally recognized pricing source based on the package size dispensed. Ø2- *Acquisition Cost (ACQ)* – Price based on the acquisition cost for the package size dispensed. Ø3- *Manufacturer Direct Price* – Price the submitter paid for the drug purchased directly from the manufacturer. Ø4- *Federal Upper Limit (FUL)* – The maximum allowable cost that federal programs will reimburse. Ø5- *Average Generic Price* – An average price of generics in the same chemical strength and dosage form of the dispensed medication. Ø6- *Usual & Customary* – The pharmacy's price for the medication for a person paying cash on the day of dispensing. Ø7- *Submitted Ingredient Cost* – Ingredient cost submitted by the pharmacy on the claim Ø8- *State MAC* – The maximum allowable unit cost as published by the State Medicaid Agency. Ø9- *Unit* – The price per unit of the drug. 1Ø- *Usual & Customary or Copay* – The pharmacy's price for the medication for a person paying cash on the day of dispensing or the patient copay whichever is less.	S	P	A/N	2	1318	1319	SCDHHS does not accept.
475-J9	DUR CO-AGENT ID QUALIFIER	Code qualifying the value in 'DUR Co-Agent ID' (476-H6).	Blank- Not Specified 01- UPC 02- HRI 03- NDC 04- HIBCC 06- DUR/PPS 07- CPT4 08- CPT5 09- HCPCS	S	C	A/N	2	1320	1321	SCDHHS does not accept.

			11- NAPPI 12- GTIN 14- GPI 15- GCN 16- GFC 17- DDID 18- First DataBank SmartKey 20- ICD9 21- ICD10 23- NCCI 24- SNOMED 25- CDT 26- DSM IV 27- ICD10-PCS 28- FDB Med Name ID 29- FDB Routed Med ID 30- FDB Routed Dosage Form Med ID 31- FDB Med ID 32- GCN_SEQ_NO 33- HICL_SEQ_NO 35- LOINC 37- AHFS 38- SCD 39- SBD 40- GPCK 41- BPCK 99- Other							
476-H6	DUR CO-AGENT ID	Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).	n/a	S	C	A/N	19	1322	1340	SCDHHS does not accept.
260	GENERIC INDICATOR	Distinguishes if product priced as Generic or Branded product: As defined by processor.	n/a	S	P	A/N	1	1341	1341	SCDHHS does not accept.
292	PLAN CUTBACK REASON CODE	Indicates the type of cutback, if any, imposed by plan.	Blank-*Not Specified* 1- *Medicare Part B (Plan Cutback)* - A reduction in a quantity of a medical service covered by Medicare Part B	S	P	A/N	1	1342	1342	SCDHHS does not accept.

			2- *Medicare Part B with days' supply cutback* - A reduction in the days' supply of a service/drug covered by Medicare Part B C- *Net Check limit cutback* - A reduction in the net amount of a check D- *Days' Supply cutback* – A reduction in the days' supply I- *Ingredient Cost cutback* - A reduction in the ingredient cost Q- *Quantity cutback* - A reduction in the quantity							
889	THERAPEUTIC CHAPTER	An eight position field representing the therapeutic chapter; from formulary file as defined by processor	n/a	S	P	A/N	8	1343	1350	SCDHHS does not accept.
209	AVERAGE COST PER QUANTITY UNIT PRICE	Average Cost Per Quantity as defined by processor.	n/a	S	P	D	9	1351	1359	SCDHHS does not accept.
210	AVERAGE GENERIC UNIT PRICE	Average Generic Price per unit as defined by processor.	n/a	S	P	D	9	1360	1368	SCDHHS does not accept.
211	AVERAGE WHOLESALE UNIT PRICE	Average Wholesale Price per unit for the drug as defined by processor.	n/a	S	P	D	9	1369	1377	SCDHHS does not accept.
253	FEDERAL UPPER LIMIT UNIT PRICE	Federal Upper Limit Unit Price as defined by processor.	n/a	S	P	D	9	1378	1386	SCDHHS does not accept.
271	MAC PRICE	Indicates the unit maximum allowable cost price for the product/service as defined by the processor.	n/a	S	P	D	9	1387	1395	SCDHHS does not accept.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	0- Not Specified 1- Ingredient Cost Paid as Submitted – Used to indicate when reimbursement is equal to the amount billed by the provider for the prescription item. 8- Contract Pricing – Price based upon contractual agreement between trading partners. 14- Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount (352-NQ).	S	C	N	2	1396	1397	SCDHHS does not accept.

285	PATIENT FORMULARY REBATE AMOUNT	Credit the patient receives on this claim from the drug manufacturer.	n/a	S	P	D	8	1398	1405	SCDHHS does not accept.
	FILLER			M	P	A/N	1254	2447	3700	SCDHHS does not accept.

8.3 POST ADJUDICATION HISTORY TRAILER RECORD

Field	Field Name	Description	Values	Mandatory or Situational	Source	Format	Size	Start	End	SCDHHS Requirement
601-04	RECORD TYPE	Type of record being submitted.	CD- *Post Adjudication History Compound Detail Record1* CE- *Post Adjudication History Compound Detail Record2* DE- *Post Adjudication History Detail Record* PA- *Post Adjudication History Header Record* PT- *Post Adjudication History Trailer Record*	M	P	A/N	2	1	2	
601-09	TOTAL RECORD COUNT	Total number of records being submitted, including header and trailer.	n/a	M	P	N	10	3	12	
895	TOTAL NET AMOUNT DUE	Summarization of Net Amount Due (281).	n/a	M	P	D	12	13	24	
693	TOTAL GROSS AMOUNT DUE	Total sum of the gross amount due fields on the claim level.	n/a	S	P	D	12	25	36	
694	TOTAL PATIENT PAY AMOUNT	Total sum of the patient pay amount fields on the claim level.	n/a	M	P	D	12	37	48	
	FILLER	n/a	n/a	M	P	A/N	3652	49	3700	

Appendix

4 Frequently Asked Questions

To be updated as questions come in.

2. Change Summary

Version	Issue Date	Modified By	Comments / Reason
.01	07/10/2013	Peg Grilliot	Original document with formatting updates
.02	07/10/2013	Tracie O'Donnell	Internal Review- updated tables.
.03	07/11/2013	Peg Grilliot	Updated document with review comments
.04	09/11/2013	Peg Grilliot	Updated document with additional review comments
.05	10/30/13	Peg Grilliot	Updated document with deletion of specified values of 00, 02-04, and 06 – 99 for 202-B2, Service Provider ID Qualifier, for 466-EZ Prescriber ID Qualifier, and for 468-2E Primary Care Provider ID Qualifier data elements. Remaining valid values as 01 and 05 for these specific data elements. Changes made per 10/30/13 hard copy request from Jeff Helliges.
.06	12/05/13	Peg Grilliot	Updated the comment section of 411-DB to reflect the accurate description of this field's value. The corrected verbiage inserted is "This is the prescribing physician's NPI."
.07	4/9/2014	Margo Noel	Mapped TOTAL AMOUNT to field 894
.08	4/23/14	Margo Noel	302-C2, 332-CY, and 896 field descriptions updated
.09	3/4/15	Hank Goff	Updated the version number, month and year on pg. 1. Added the Original Transaction ID and Void Transaction Identifier rows in the Header on pages 18 and 19. Adjusted the filler information on pg. 19. On the Transaction ID row, pg. 185, added the Void Process to the SC DHHS Requirement column. Changes approved by Jon Tapley and Michael Kellett on 03/06/15.
.10	04/14/15	Hank Goff	Updated the version number and month on pg. 1. Moved the Original Transaction ID and Void Transaction Identifier rows from the Header record to the Detail record. Adjusted the filler information on the header record and the detail record. On the Transaction ID row, pg. 182, added the updated Void Process to the SC DHHS Requirement column. Updated the reimbursement indicator information in the 522-FM fields.