CONDUENT

HEALTH CARE AUTHORITY

D.0 FFS Payer Sheet B1, B2, B3

New Mexico Health Care Authority
MMISR Financial Services Project

Version 1.0

Revision History

This section tracks the initial creation of this document, followed by information about each major version thereafter.

Revision History

Version	Date	Description	Author	HCA Approval
1.0	01/21/2026	HCA Approved	Conduent Team	Diana Moya

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1. Request Claim Billing/Claim Rebill (B1/B2/B3) Payer Sheet

1.1. Request Claim Billing/Claim Rebill (B1/B3)

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

GENERAL INFORMATION

Payer Name: New Mexico Medicaid	Date: March 22, 2026	
Plan Name/Group Name: NM Medicaid Fee For Service	BIN: 028165	PCN: DRNMPROD
Plan Name/Group Name: NM Medicaid Fee For Service (test)	BIN: 026564	PCN: DRNMUAAZFR
Processor: Conduent		
Effective as of: March 22, 2026	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: October 2007	NCPDP External Code List Version Date: March 2010	
Contact/Information Source: https://www.hca.nm.gov/providers/hippa-standard-companion-guides/		
Certification Testing Window: None (certification not required)		
Certification Contact Information: N/A		
Provider Relations Help Desk Info: 1-800-365-4944 Option #3		
Other versions supported: 5.1 supported through 12/31/2011		

OTHER TRANSACTIONS SUPPORTED

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

Transaction Code	Transaction Name
B1	Claim Billing
B2	Reversal
B3	Claim Rebilling

FIELD LEGEND FOR COLUMNS

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

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

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	**Check**	**Claims Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used.	X	

	Transaction Header Segment			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
1Ø1-A1	BIN NUMBER	Ø28165 = PROD Ø26564 = UAT	M	
1Ø2-A2	VERSION/RELEASE NUMBER	D0	M	
1Ø3-A3	TRANSACTION CODE	B1 = Billing B2 = Reversals B3 = Rebill	M	Billing, Reversal, Rebill
1Ø4-A4	PROCESSOR CONTROL NUMBER	DRNMPROD = Production DRNMUAAZFR = UAT	M	Use DRNMUAAZFR for D.0 testing through March 22, 2026
1Ø9-A9	TRANSACTION COUNT	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Ø1=National Provider Identifier	M	NPI mandated 02/01/2008
2Ø1-B1	SERVICE PROVIDER ID	National Provider Identifier (NPI)	M	NPI mandated 02/01/2008
4Ø1-D1	DATE OF SERVICE	CCYYMMDD	M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	ØØØØØØØØØØ	M	Populate with zeros

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

	Insurance Segment **Segment Identification (111-AM) = "Ø4"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø2-C2	CARDHOLDER ID		M	
312-CC	CARDHOLDER FIRST NAME	Up to 12 characters	R	
313-CD	CARDHOLDER LAST NAME	Up to 15 Characters	R	
3Ø1-C1	GROUP ID	NEWMEXMED	R	*Imp Guide*: Required if needed for pharmacy claim processing and payment.
3Ø6-C6	PATIENT RELATIONSHIP CODE	1 = Cardholder	R	*Imp Guide*: Required if needed to uniquely identify the relationship of the Patient to the Cardholder.

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

	Patient Segment **Segment Identification (111-AM) = "Ø1"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
3Ø4-C4	DATE OF BIRTH	CCYYMMDD	R	
3Ø5-C5	PATIENT GENDER CODE	Ø= Not specified 1 = Male 2 = Female	R	
335-2C	PREGNANCY INDICATOR	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	*Imp Guide*: Required if pregnancy could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Required if pregnant.
384-4X	PATIENT RESIDENCE	Ø=Not specified 3=Nursing Facility 9=Intermediate Care Facility/ Individuals with Intellectual Disabilities 11=Hospice 15=Correctional Institution	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Required to indicate patient residence in any of the facilities indicated.

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

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	*Imp Guide*: For Transaction Code of "B1", in the Claim Segment, the Prescription / Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER	Ø3 = National Drug Code	M	
4Ø7-D7	PRODUCT/SERVICE ID	National Drug Code (NDC)	M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER	Rx number of the associated partial fill claim	RW	*Imp Guide*: Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C"). Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement*: Same as Imp Guide.
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	Used when submitting a claim for a partial fill	RW	*Imp Guide*: Required if the "completion" transaction in a partial fill (Dispensing Status (343- HD) = "C" (Completed)).

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
				Required if Associated Prescription / Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. *Payer Requirement:* Date of the Associated Prescription/Service Reference Number.
442-E7	QUANTITY DISPENSED	Metric Decimal Quantity	R	
46Ø -ET	QUANTITY PRESCRIBED	Metric Decimal Quantity	R	*Payer Requirement:* Required under New Mexico Board of Pharmacy rules and when the transmission is for a Schedule II drug as defined in 21 CFR 1308.12 and per CMS-0055-F (Compliance Date 9/21/2020. Refer to the Version D.0 Editorial Document).
4Ø3-D3	FILL NUMBER	Ø = Original Dispensing 1-99 = Refill number	R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE	Ø = Not specified 1 = Not a compound 2 = Compound	R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	Ø =Default, no product selection indicated 1=Physician request 7=brand mandated by law 8 = Substitution Allowed - Generic Drug Not Available in Marketplace. 9= Other/Substitution Allowed-Plan Requests Brand Dispensed.	R	*Payer Requirement:* Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. Value '1' may be used when physician requests meet the Medicaid Program standards for a brand being medically necessary. *Payer Requirement:* Pharmacy should use Value '9' when preferred drugs are brand based on New Mexico PDL.
414-DE	DATE PRESCRIPTION WRITTEN	CCYYMMDD	R	
419-DJ	PRESCIPTION ORIGIN CODE	1=Written 2=Telephone 3=Electronic 4=Facsimile 5=Pharmacy	R	*Imp Guide*: Required if necessary for plan benefit administration. *Payer Requirement:* Required. Value Ø (not specified) will not be accepted by NM.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Maximum count of 3.	RW	*Imp Guide*: Required if Submission Clarification Code (42Ø-DK) is used. *Payer Requirement*: Same as Imp Guide.
42Ø-DK	SUBMISSION CLARIFICATION CODE	Ø8=Process Compound for approved ingredients. Ø7 = Over Limits for Narcan 43 = Prescriber's DEA is active with DEA Authorized Prescriptive Right. 45 = Prescriber's DEA is a valid Hospital DEA with Suffix and has prescriptive authority for this drug DEA Schedule 46 = Prescriber's DEA has prescriptive authority for this drug DEA Schedule 55= Used when overriding rejection for Prescriber Not Enrolled in State Medicaid Program (for NM Medical	R	*Imp Guide*: Required if clarification is needed and value submitted is greater than zero (Ø). *Payer Requirement*: Required when submitting a claim for a DEA Scheduled Drug (I through V) and/or for the listed conditions.

	Claim Segment **Segment Identification (111-AM) = "Ø7"**			**Claim Billing/Claim Rebill**
		School Residents.)99 = Other – (use for submitting MAID prescriptions)		
3Ø8-C8	OTHER COVERAGE CODE	Ø =Not Specified 1=No other Coverage 2=Other coverage exists - payment collected 3=Other coverage billed - claim not covered 4=Other coverage exists - payment not collected.	RW	*Imp Guide*: Required if needed by receiver, to communicate a summation of other coverage information collected from other payers. Required for Coordination of Benefits. *Payer Requirement*: Required when other coverage exists.
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE		RW	*Imp Guide*: Required if the receiver requests association to a therapeutic, or a preferred product substitution, or when a DUR alert has been resolved by changing medications, or an alternative service than what was originally prescribed. *Payer Requirement*: Code of the initially prescribed product or service.
461-EU	PRIOR AUTHORIZATION TYPE CODE	Ø=Not Specified 1=Prior Authorization 2=Medical Certification	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Use '1' in this field when submitting claims for Children's Medical Services Use '2' in this field for early Refill override – when authorized by the POS help desk.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, or patient financial responsibility. *Payer Requirement*: Required if valid value in field 461-EU is '1' and a number is required to be submitted.
343-HD	DISPENSING STATUS	P = Initial Fill C = Completion Fill	RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement*: Same as Imp Guide.
344-HF	QUANTITY INTENDED TO BE DISPENSED		RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement*: Required when submitting a claim for a partial fill.
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED		RW	*Imp Guide*: Required for the partial fill or the completion fill of a prescription. *Payer Requirement*: Required when submitting a claim for a partial fill.
995-E2	ROUTE OF ADMINISTRATION	SNOMED Values Required	RW	*Imp Guide*: Required if specified in trading partner agreement. *Payer Requirement*: Required when submitting compounds.

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

	Pricing Segment **Segment Identification (111-AM) = "11"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		RW	*Imp Guide*: Required if its value affects the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Required, if necessary, as component part of Gross Amount Due.
438-E3	INCENTIVE AMOUNT SUBMITTED		R	*Imp Guide*: Required if its value affects the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement*: Required when submitting for Vaccine administration or Pharmacist prescribed medications. Format = $$$$$$cc Example: if the Incentive amount submitted is $27.31, this field would reflect 2731. Use field for reimbursement of compounding fee (up to $12.00).
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	RW	*Imp Guide*: Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. *Payer Requirement*: Same as Imp Guide.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	Ø9=Compound Preparation Cost Submitted	RW	*Imp Guide*: Required if Other Amount Claimed Submitted (48Ø-H9) is used. *Payer Requirement*: If a compounding fee is being requested in addition to the dispensing fee enter Ø9.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		RW	*Imp Guide*: Required if its value affects the Gross Amount Due (43Ø-DU) calculation. *Payer Requirement* : NM providers enter compound fee in this field.
426-DQ	USUAL AND CUSTOMARY CHARGE		R	*Imp Guide:* Required if needed per trading partner agreement. *Payer Requirement:* Amount charged by cash customers for the prescription exclusive of sales tax or other amounts claimed.
43Ø-DU	GROSS AMOUNT DUE		R	*Payer Requirement:* This field is required to be submitted in D.0.
423-DN	BASIS OF COST DETERMINATION	Ø8 = 340B/Disproportionate Share Pricing/Public Health Service	R	*Imp Guide*: Required if needed for receiver claim/encounter adjudication. *Payer Requirement*: Required to identify 340B acquisition cost.

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

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
466-EZ	PRESCRIBER ID QUALIFIER	Ø1=National Provider ID	R	*Imp Guide*: Required if Prescriber ID (411-DB) is used. *Payer Requirement* :Prescriber NPI is required.
411-DB	PRESCRIBER ID	National Provider Identifier (NPI)	R	*Imp Guide*: Required if this field could result in different coverage or patient financial responsibility. *Payer Requirement*: Prescriber must be an enrolled Medicaid Provider OR NM Medical School Resident authorized to prescribe (submit with Submission Clarification Code 55).
427-DR	PRESCRIBER LAST NAME	Prescriber's Last Name	R	*Imp Guide:* Required when the Prescriber ID (411-DB) is not known. Required if needed for Prescriber ID (411-DB) validation/clarification. *Payer Requirement:* Individual's Last Name (15 characters) First 5 characters must match Example: MOUSE
364-2J	PRESCRIBER FIRST NAME	Prescriber's First Name	R	*Imp Guide*: Required if needed to assist in identifying the prescriber. *Payer Requirement*: Individual's First Name (12 characters) First 5 characters must match. Example: MICKEY
498-PM	PRESCRIBER PHONE NUMBER	Prescriber's Phone Number	R	*Imp Guide*: Required if needed for Workers' Compensation. Required if needed to assist in identifying the prescriber. Required if needed for Prior Authorization process. *Payer Requirement*: Ten-digit phone number of prescriber. FORMAT: AAAEEENNNN A= Area Code E= Exchange Code N=Number
365-2K	PRESCRIBER STREET ADDRESS	Prescriber's Street Address	R	*Imp Guide:* Required if needed to assist in identifying the prescriber. *Payer Requirement:* Free form text for prescriber address information (30 characters).
366-2M	PRESCRIBER CITY ADDRESS	Prescriber's City	R	*Imp Guide:* Required if needed to assist in identifying the prescriber. *Payer Requirement:* Free form text for prescriber city name (20 characters).
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS	Prescriber's State	R	*Imp Guide:* Required if needed to assist in identifying the prescriber. *Payer Requirement*: Standard State Code (2 characters) Example: New Mexico = NM.
368-2P	PRESCRIBER ZIP/POSTAL ZONE	Prescriber's Zip Code	R	*Imp Guide:* Required if needed to assist in identifying the prescriber.

	Prescriber Segment **Segment Identification (111-AM) = "Ø3"**			**Claim Billing/Claim Rebill**
				Payer Requirement: Code defining international postal zone excluding punctuation marks (15 characters max). First 5 digits must match.

Coordination of Benefits/Other Payments Segment Questions	**Check**	**Claims Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent	X	
This Segment is situational	X	Required only for secondary, tertiary, etc. claims.
This Segment is not supported		
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)	X	

	Coordination of Benefits/Other Payments Segment **Segment Identification (111-AM) = "Ø5"**			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE	Blank=Not Specified Ø1=Primary Ø2=Secondary - Second Ø3=Tertiary - Third Ø4=Quaternary - Fourth Ø5=Quinary - Fifth	M	
339-6C	OTHER PAYER ID QUALIFIER	Ø3=Bank Information Number (BIN) 99=Other	RW	*Imp Guide*: Required if Other Payer ID (34Ø-7C) is used. *Payer Requirement*: Submit value "99" and NM Carrier code in 34Ø-7C if known. Otherwise use "Ø3" and submit BIN of previous payer in 34Ø-7C.
34Ø-7C	OTHER PAYER ID		RW	*Imp Guide*: Required if identification of the Other Payer is necessary for claim/encounter adjudication. *Payer Requirement*: Submit NM Carrier Code if known, otherwise submit BIN of previous payer.
443-E8	OTHER PAYER DATE	CCYYMMDD	RW	*Imp Guide*: Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. *Payer Requirement*: Required when there is payment or denial from another source.
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.	RW	*Imp Guide*: Required if Other Payer Amount Paid Qualifier (342-HC) is used.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
				Payer Requirement: Same as Imp Guide.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø9=Compound Preparation Cost 1Ø =Sales Tax	RW	*Imp Guide*: Required if Other Payer Amount Paid (431-DV) is used. *Payer Requirement*: Required when there is payment from another source. Required when 3Ø8-C8 = '2'.
431-DV	OTHER PAYER AMOUNT PAID	S$$$$$$cc	RW	*Imp Guide*: Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. *Payer Requirement*: Required if OCC = 2.
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.	RW	*Imp Guide*: Required if Other Payer Reject Code (472-6E) is used. *Payer Requirement*: Required if 3Ø8-C8 (Other Coverage Code) = 3 (Other Coverage Billed – claim not covered).
472-6E	OTHER PAYER REJECT CODE		RW	*Imp Guide*: Required when the other payer has denied the payment for the billing. *Payer Requirement*: Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered).
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.	RW	*Imp Guide*: Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. *Payer Requirement*: Same as Imp Guide.
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Ø1=Amt Applied to Periodic Deductible Ø2=Amt Attributed to Product Selection/Brand Drug Ø3=Amt Attributed to Sales Tax Ø4=Amt Exceeding Periodic Benefit Maximum Ø5=Amount of Copay Ø6=Patient Pay Amount Ø7=Amount of Coinsurance Ø8=Amt Attributed to Product Selection/Non-Pref Formulary Ø9=Amt Attributed to Health Plan Funded Assistance Amount 1Ø = Amt Attributed to Provider Network Selection 11=Amt Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12=Amt Attributed to Coverage Gap	RW	*Imp Guide*: Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. *Payer Requirement*: Same as Imp Guide.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			**Claim Billing/Claim Rebill** Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
		13=Amt Attributed to Processor Fee		
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT		RW	*Imp Guide*: Required if necessary for patient financial responsibility only billing. *Payer Requirement*: Required when Other Coverage Code 3Ø8-C8 = '2' or '4'.

DUR/PPS Segment Questions	**Check**	**Claims Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required if DUR/PPS Segment is used.

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.	RW	*Imp Guide*: Required if DUR/PPS Segment is used. *Payer Requirement*: Same as Imp Guide.
439-E4	REASON FOR SERVICE CODE	See list of Valid Values in section 2.0 below	O	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service: *Payer Requirement*: Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.
44Ø-E5	PROFESSIONAL SERVICE CODE	MA=Medication administration Use 'MA' for vaccine administration. AS = Patient Assessment, use for Pharmacist incentive fee under prescriptive authority. See list of Valid Values in section 2.0 below for further guidance for submitting Pharmacist-prescribed medications.	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement:* Must enter a value when Incentive Amount Submitted (438-E3) is greater than zero (Ø). Enter one professional service code only, indicating the type of service. NM Medicaid Valid Values: MA = Medication Administration For Vaccines AS= Patient Assessment – For Pharmacist-prescribed medications.
441-E6	RESULT OF SERVICE CODE	See list of Valid Values in section 2.0 below	O	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome.

	DUR/PPS Segment **Segment Identification (111-AM) = "Ø8"**			**Claim Billing/Claim Rebill**
				Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement*: Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.
474-8E	DUR/PPS LEVEL OF EFFORT	Ø= Not Specified 11=Level 1 (Lowest) 12=Level 2 13=Level 3 14=Level 4 15=Level 5	RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement*: 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.
475-J9	DUR CO-AGENT ID QUALIFIER		RW	*Imp Guide*: Required if DUR Co-Agent ID (476-H6) is used. *Payer Requirement*: Same as Imp Guide.
476-H6	DUR CO-AGENT ID		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. *Payer Requirement*: Identifies the co-existing agent contributing to the DUR event (drug or disease conflicting with the prescribed drug or prompting pharmacist professional service).

Compound Segment Questions	**Check**	**Claims Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required when the claim is a compound

	Compound Segment **Segment Identification (111-AM) = "1Ø"**			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup	M	*Payer Requirement:* Dosage form of the complete admixture.

	Compound Segment Segment Identification (111-AM) = "1Ø"			**Claim Billing/Claim Rebill**
		17 = Lozenge 18 = Enema		
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	1 = Each 2 = Grams 3 = Milliliters	M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	*Payer Requirement*: Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	COMPOUND PRODUCT ID QUALIFIER	Ø3 = NDC	M	
489-TE	COMPOUND PRODUCT ID	NDC	M	
448-ED	COMPOUND INGREDIENT QUANTITY	9(7)v999	M	
449-EE	COMPOUND INGREDIENT DRUG COST		RW	*Imp Guide*: Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement*: Use to submit compound ingredient cost paid. Populate as $0.00 if nothing was paid for the particular ingredient.
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Ø8 = 340B / Disproportionate Share Pricing/Public Health	RW	*Imp Guide*: Required if needed for receiver claim determination when multiple products are billed. *Payer Requirement*: Submit Ø8 to identify 340B acquisition cost.

Clinical Segment Questions	**Check**	**Claims Billing/Claim Rebill** If Situational, *Payer Situation*
This Segment is always sent		
This Segment is situational	X	Required if the claim is for a GLP-1 medication

	Clinical Segment Segment Identification (111-AM) = "13"			**Claim Billing/Claim Rebill**
Field	*NCPDP Field Name*	*Value*	*Payer Usage*	*Payer Situation*
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5	RW	*Imp Guide:* Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. *Payer Requirement*: Same as Imp Guide.
492-WE	DIAGNOSIS CODE QUALIFIER	Ø2 = ICD1Ø	RW	*Imp Guide:* Required if the Diagnosis Code (424-DO) is used. *Payer Requirement*: Same as Imp Guide.
424-DO	DIAGNOSIS CODE		RW	*Imp Guide*: Required if this field could result in different coverage, pricing, patient financial responsibility and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. *Payer Requirement*: Required for GLP-1 medications. The value for this field is obtained from the prescriber or authorized representative.

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

1.2. Claim Reversal Transaction (B2)

Claim reversals (B2 Transactions) use the same Transaction Header Segment, Insurance Segment, and Claim Segment as Claim billing (B1) and Claim rebilling (B3) above. Other segments are not supported **for claim reversals**.

2. DUR Override Code Valid Values

MEDICATION ASSISTED TREATMENTS

439-E4 REASON FOR SERVICE CODES	441-E6 RESULT OF SERVICE CODE
AD – Additional Drug Needed	1B – Filled Prescription As-Is
MN – Insufficient Duration	1D – Filled, with Different Directions
ND – New disease/diagnosis	1G – Filled with Prescriber Approval
PN – Prescriber Consultation	3B – Recommendation not Accepted
	3H – Follow Up/Report

PRENATAL THERAPY

439-E4 REASON FOR SERVICE CODES	441-E6 RESULT OF SERVICE CODE
CD – Chronic Disease Management	1B – Filled Prescription As-Is
ND – New disease/diagnosis	3B – Recommendation not Accepted
PA – Drug- Age	3E – Therapy Changed
PG – Drug Pregnancy	
PN – Prescriber Consultation	
SX – Drug-Gender	

PREGNANCY DUR

439-E4 REASON FOR SERVICE CODES	441-E6 RESULT OF SERVICE CODE
PG – Drug Pregnancy	1B – Filled Prescription As-Is
PN – Prescriber Consultation	1C – Filled with Different Dose
CD – Chronic Disease Management	1D – Filled with Different Directions
	3B – Recommendation not Accepted

PHARMACIST PRESCRIPTIVE AUTHORITY

439-E4 REASON FOR SERVICE CODES	441-E6 RESULT OF SERVICE CODE
DM- Drug misuse	1B – Filled Prescription As-Is
ND – New disease/diagnosis	3B – Recommendation not Accepted
PP – Plan Protocol	3N – Medication Administered
DS- Tobacco Use	
PH– Preventive Health	
PC – Patient Concern	
MC – Drug disease reported	

Medications Authorized for Incentive Fee when prescribed and dispensed by a Prescribing Pharmacist
Hormonal Contraception
Smoking Cessation
Naloxone Prescribing
TB Testing
HIV PrEP
Covid-19 Treatment

3. Compound Claim Pricing

For compounding pharmacies, refer to section 4.19-B in the NM state plan New Mexico Medicaid State Plan – New Mexico Health Care Authority; section Attachment 4.19-B Methods and Standards for Establishing Payment Rates Other Types for details regarding reimbursement of compounding fees.

4. Professional Billing

Please see the *837P Quick Sheet for Pharmacist Medication Management Services* available at 5010 HIPAA - Guides, FAQs and Submission Procedures – New Mexico Health Care Authority, to help facilitate the submission of pharmacist claim transaction data via the 837P Transaction to the State of New Mexico.