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HIGHLIGHTS – Updates, Changes & Reminders

This payer sheet refers to Medicare Part D Primary Billing and Medicare as Secondary Payer Billing. Refer to www.Aetna.com under the Health Care Professionals link for additional payer sheets.

To prevent point of service disruption, the RxGroup must be submitted on all claims and reversals.

The following is a summary of our new requirements. The items highlighted in the payer sheet illustrate the updated processing rules.

- **Updated ECL Version to Oct 2018**
- **Updated Emergency ECL Version to Jan 2019**

PART 1: GENERAL INFORMATION

Payer/Processor Name: Aetna

Plan Name/Group Name: All

Effective as of: October 2Ø19

Payer Sheet Version: 1.5.7

NCPDP Version/Release #: D.Ø

NCPDP ECL Version: **Oct 2Ø18**

NCPDP Emergency ECL Version: **Jan 2Ø19**

- **Pharmacy Help Desk Information**

Inquiries can be directed to the Interactive Voice Response (IVR) system or the Pharmacy Help Desk. (24 hours a day)

The Pharmacy Help Desk numbers are provided below:

Aetna System	BIN	Help Desk Number
Aetna	610502	1-8ØØ-238-6279

PART 2: BILLING TRANSACTION / SEGMENTS AND FIELDS

The following table lists the segments available in a Billing Transaction. Pharmacies are required to submit upper case values on B1/B2 transactions. The table also lists values as defined under Version D.Ø. The Transaction Header Segment is mandatory. The segment summaries included below list the mandatory data fields.

M – Mandatory as defined by NCPDP
R – Required as defined by the Processor
RW – Situational as defined by Plan

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
1Ø1-A1	BIN Number	610502	M	
1Ø2-A2	Version/Release Number	DØ	M	NCPDP vD.Ø
1Ø3-A3	Transaction Code	B1	M	Billing Transaction
1Ø4-A4	Processor Control Number		M	Use value as printed on ID card, as communicated by Aetna or as stated in Appendix A
1Ø9-A9	Transaction Count	1, 2, 3, 4	M	
2Ø2-B2	Service Provider ID Qualifier	Ø1	M	Ø1 – NPI
2Ø1-B1	Service Provider ID		M	National Provider ID Number assigned to the dispensing pharmacy
4Ø1-D1	Date of Service		M	CCYYMMDD
11Ø-AK	Software Vendor/Certification ID		M	The Software Vendor/Certification ID is the same for all BINs. Obtain your certification ID from your software vendor. Your Software Vendor/Certification ID is 1Ø bytes and should begin with the letter “D”.

PART 3: REVERSAL TRANSACTION

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
1Ø1-A1	BIN Number	610502	M	The same value in the request billing
1Ø2-A2	Version/Release Number	DØ	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number		M	The same value in the request billing
1Ø9-A9	Transaction Count		M	Up to four billing reversal transactions (B2) per transmission
2Ø2-B2	Service Provider ID Qualifier	Ø1	M	Ø1 – NPI
2Ø1-B1	Service Provider ID		M	NPI – National Provider ID Number assigned to the dispensing pharmacy. The same value in the request billing
4Ø1-D1	Date of Service		M	The same value in the request billing – CCYYMMDD
11Ø-AK	Software Vendor/Certification ID		M	The Software Vendor/Certification ID is the same for all BINs. Obtain your certification ID from your software vendor. Your Software Vendor/Certification ID is 1Ø bytes and should begin with the letter “D”.

Insurance Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID		RW	Required when segment is sent
3Ø1-C1	Group ID		RW	Required when segment is sent

Claim Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1	M	1 – Rx Billing
4Ø2-D2	Prescription/Service Reference Number		M	Same value as in request billing
436-E1	Product/Service ID Qualifier		M	Same value as in request billing
4Ø7-D7	Product/Service ID		M	Same value as in request billing
4Ø3-D3	Fill Number		R	Same value as in request billing
3Ø8-C8	Other Coverage Code		RW	Same value as in request billing
147-U7	Pharmacy Service Type		RW	Same value as in request billing

PART 4: PAID (OR DUPLICATE OF PAID) RESPONSE

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
1Ø2-A2	Version/Release Number	DØ	M	NCPDP vD.Ø
1Ø3-A3	Transaction Code		M	Same value as in request billing
1Ø9-A9	Transaction Count		M	1-4 occurrences supported for B1 transaction
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier		M	Same value as in request billing
2Ø1-B1	Service Provider ID		M	Same value as in request billing
4Ø1-D1	Date of Service		M	Same value as in request billing – CCYYMMDD

Response Message Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Response Message Segment
5Ø4-F4	Message		RW	Required when text is needed for clarification or detail

Response Insurance Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	25	M	Response Insurance Segment
3Ø1-C1	Group ID		RW	This field may contain the Group ID echoed from the request

Response Patient Segment: Required

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	29	M	Response Insurance Segment
31Ø-CA	Patient First Name		RW	Required when needed to clarify eligibility
311-CB	Patient Last Name		RW	Required when needed to clarify eligibility
3Ø4-C4	Date of Birth		RW	Required when needed to clarify eligibility – CCYYMMDD

PART 5: REJECT RESPONSE

Transaction Header Segment: Mandatory

Field #	NCPDP Field Name	Value	Req	Comment
1Ø2-A2	Version/Release Number	DØ	M	NCPDP vD.Ø
1Ø3-A3	Transaction Code		M	Billing Transaction Same value as in request billing B1
1Ø9-A9	Transaction Count		M	Same value as in request billing
5Ø1-F1	Header Response Status	A	M	
2Ø2-B2	Service Provider ID Qualifier		M	Same value as in request billing
2Ø1-B1	Service Provider ID		M	Same value as in request billing
4Ø1-D1	Date of Service		M	Same value as in request billing – CCYYMMDD

Response Message Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	2Ø	M	Response Message Segment
5Ø4-F4	Message		R	

Response Insurance Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	25	M	Response Insurance Segment
3Ø1-C1	Group ID		RW	This field may contain the Group ID echoed from the request

Response Patient Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	29	M	Response Patient Segment
31Ø-CA	Patient First Name		RW	Required when needed to clarify eligibility
311-CB	Patient Last Name		RW	Required when needed to clarify eligibility
3Ø4-C4	Date of Birth		RW	Required when needed to clarify eligibility – CCYYMMDD

Response DUR/PPS Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	24	M	Response DUR/PPS Segment
567-J6	DUR / PPS Response Code Counter	Max of 9	RW	Required when Reason for Service Code (439-E4) is used
439-E4	Reason for Service Code		RW	Required when utilization conflict is detected
528-FS	Clinical Significance Code		RW	Required when needed to supply additional information for the utilization conflict
529-FT	Other Pharmacy Indicator		RW	Required when needed to supply additional information for the utilization conflict
53Ø-FU	Previous Date of Fill		RW	Required when needed to supply additional information for the utilization conflict – CCYYMMDD
531-FV	Quantity of Previous Fill		RW	Required when needed to supply additional information for the utilization conflict
532-FW	Database Indicator		RW	Required when needed to supply additional information for the utilization conflict
533-FX	Other Prescriber Indicator		RW	Required when needed to supply additional information for the utilization conflict
544-FY	DUR Free Text Message		RW	Required when needed to supply additional information for the utilization conflict
57Ø-NS	DUR Additional Text		RW	Required when Reason for Service Code (439-E4) is used

Response Coordination of Benefits Segment: Situational

Field #	NCPDP Field Name	Value	Req	Comment
111-AM	Segment Identification	28	M	Response Coordination of Benefits Segment
355-NT	Other Payer ID Count	Max of 3	M	
338-5C	Other Payer Coverage Type		M	
339-6C	Other Payer ID Qualifier		RW	Required when Other Payer ID (34Ø-7C) is used
34Ø-7C	Other Payer ID		RW	Required when other insurance information is available for coordination of benefits
991-MH	Other Payer Processor Control Number		RW	Required when other insurance information is available for coordination of benefits
356-NU	Other payer Cardholder ID		RW	Required when other insurance information is available for coordination of benefits
992-MJ	Other Payer Group ID		RW	Required when other insurance information is available for coordination of benefits
142-UV	Other payer Person Code		RW	Required when needed to uniquely identify the family members within the Cardholder ID, as assigned by the other payer
127-UB	Other Payer Help Desk Phone Number		RW	Required when needed to provide a support telephone number of the other payer to the receiver
143-UW	Other Payer Patient Relationship Code		RW	Required when needed to uniquely identify the relationship of the patient to the cardholder ID, as assigned by the other payer

APPENDIX A: BIN / PCN COMBINATIONS

- **Medicare Part D – Primary BIN and PCN Values**

Other PCNs may be required as communicated or printed on card.

BIN	Processor Control Number
610502	MEDDAET PARTBAET

Aetna will respond back to the pharmacy in the message text fields indicating any other coverage that may apply to Medicare Part D members. Please ensure that pharmacy employees can easily read this information so that supplemental claims can be submitted according to the message instructions.

Only one Medicare Part D claim transaction is allowed per transmission.

APPENDIX B: MEDICARE PART D

- **Medicare Part D – Patient Residence**

To ensure proper reimbursement, it is important that Provider submit accurate Patient Residence and Pharmacy Service Type values on Medicare Part D claims based on the pharmacy's Medicare Part D network participation. Patient Residence and Pharmacy Service Type fields must be submitted to identify Home Infusion, Long-Term Care, Assisted Living Facility and Retail Claims.

Aetna will accept the following values:

Retail Claim Type	Patient Residence (Field 384-4X)	Pharmacy Service Type (Field 147-U7)
Retail	Ø1	Ø1

Assisted Living Facility Claim Type	Patient Residence (Field 384-4X)	Pharmacy Service Type (Field 147-U7)
Assisted Living Facility (Retail)	Ø4	Ø5
Home Infusion	Ø4	Ø3

Home Infusion Claim Type	Patient Residence (Field 384-4X)	Pharmacy Service Type (Field 147-U7)
Home Infusion	Ø1	Ø3
Long-Term Care Home Infusion	Ø4	Ø3

Long Term Care Claim Type	Patient Residence (Field 384-4X)	Pharmacy Service Type (Field 147-U7)
Long-Term Care	Ø3	Ø5
Long-Term Care Institutional	Ø3	Ø4
Long-Term Care Home Infusion	Ø1	Ø3
Long-Term Care ICF/IID* *ICF/IID is exempt from short cycle dispensing	Ø9	Ø5

- **Medicare Part D – Prescriber NPI Requirements**

Prescriber Identification Requirements

Effective January 1, 2013, **identification of the Prescriber requires a valid and active National Provider Identifier (NPI).** Per CMS, all Medicare Part D claims, including controlled substance prescriptions, must be submitted with the Prescriber's valid and active NPI. It is not acceptable, at any time, to utilize an invalid or inactive NPI which does not represent a Prescriber. For pharmacies, it is imperative that the NPI of the Prescriber is checked and verified instead of simply selecting the first number that appears during the Prescriber search.

Claims Submission

There must be a valid and active individual NPI number submitted with each claim. Otherwise, a claim will reject for Invalid Prescriber. An accurate Submission Clarification Code (NCPDP Field # 420-DK) may be submitted to allow a rejected claim to pay.

- **Claims submitted and reimbursed by Aetna without a valid and active NPI will result in audit review and chargeback**
- Provider must maintain the DEA number on the original hard copy for all controlled substances prescriptions in accordance with State and Federal laws
- For unresolved rejects, Aetna is required by CMS to contact pharmacies within 24 hours of the reject
- The requirement also applies to foreign Prescribers
- Upon submission of an SCC code, the pharmacy is CONFIRMING the validity of that Prescriber to prescribe the drug
- If calling to request a Prior Authorization, the pharmacy understands that the Prescriber Identifier is considered invalid and will be subject to retrospective audit and possible chargeback

PHARMACY STEPS:

In the event a claim rejects for prescriber ID, please review the following steps:

- **Verify the ID submitted is a Type 1 NPI.**
- **For controlled drugs, confirm the Prescriber has a valid DEA and is authorized to prescribe that particular class of drugs**

Please note: Only certain SCC codes will be allowed to override each reject code, please see below to help determine valid SCC codes for each reject.

Reject Code	Field #	Code Value	Description
A2,42, 56	42Ø-DK Submission Clarification Code	42	The Prescriber ID submitted has been validated, is active
43, 44	42Ø-DK Submission Clarification Code	43, 45	For the Prescriber ID submitted, associated prescriber DEA Renewed, or In Progress, DEA Authorized Prescriptive Rights. For the Prescriber ID submitted, associated DEA is a valid Hospital DEA with Suffix
46	42Ø-DK Submission Clarification Code	46	For the Prescriber ID submitted and associated prescriber DEA, the DEA has authorized prescriptive rights for this drug DEA Class
619	42Ø-DK Submission Clarification Code	42, 49	The Prescriber ID submitted has been validated, is active. Prescriber does not currently have an active Type 1 NPI.

- **Medicare Part D – Use of Prescription Origin Code**

The September 17, 2ØØ9, memorandum from Medicare and Medicaid Services (CMS) provided clarification on earlier guidance on the Prescription Origin Code ("Upcoming Drug Data Processing System (DDPS) Changes").

Providers must use a valid Prescription Origin Code (values 1-4) when submitting ***original fills*** for Medicare Part D electronic point of sale claims. Effective January 1, 2Ø1Ø, ***original fills*** claims submitted without one of the values below will be rejected.

Blank and "Ø" (Not Specified) Prescription Origin Code values will no longer be valid values for original fill Medicare Part D claims submitted in standard format with dates of service beginning January 1, 2Ø1Ø.

Effective January 1, 2Ø1Ø all Medicare Part D claims with a 2Ø1Ø date of service, will require the Prescription Origin Code and Fill number on all Original Dispensing.

A. Please submit one of the following data elements within Prescription Origin Code (419-DJ):

Blank or Ø – Not Specified (not valid on Medicare Part D Original Fill)
1 – Written
2 – Telephone
3 – Electronic
4 – Facsimile
5 – Pharmacy

B. Please submit one of the following data elements within Fill Number (4Ø3-D3):
Ø – Original dispensing
1 to 99 – Refill Number

NCPDP Field #	Segment & Field Name	Required for Original Fill Medicare Part D transactions.
419-DJ	Claim Segment Prescription Origin Code	1 – Written 2 – Telephone 3 – Electronic 4 – Facsimile 5 – Pharmacy
4Ø3-D3	Claim Segment Fill Number	Ø – Original dispensing

- **Medicare Part D – Vaccine Processing**

Dispensing and Administering the Vaccine
If Provider dispenses the vaccine medication and administers the vaccine to the enrollee, submit both drug cost and vaccine administration information on a single claim. The following fields are required in order for the claim to adjudicate and reimburse Provider appropriately for vaccine administration:

NCPDP Field #	Segment & Field Name	Required Vaccine Administration Information for Processing
44Ø-E5	DUR/PPS Segment Professional Service Code Field	**MA** (Medication Administration)
438-E3	Pricing Segment Incentive Amount Submitted Field	**≥ $0.01** (Submit Administration Fee)

Dispensing the Vaccine Only
If Provider dispenses the vaccine medication only, submit the drug cost electronically according to current claims submission protocol.

Vaccine Administration Only
Aetna will reject on-line claim submissions for vaccine administration only. Therefore, if Provider dispenses the vaccine medication and administers the vaccine to the enrollee, submit both elements on a single claim transaction electronically to Aetna.

Vaccine Drug Coverage
Please rely on Aetna's on-line system response to determine Medicare Part D vaccine drug coverage for Medicare Part D plans adjudicating through Aetna. As a reminder—pharmacists are required to be certified and/or trained to administer Medicare Part D vaccines. Please check with individual state boards of pharmacy to determine if pharmacists can administer vaccines in your respective state(s).

Submitting a Primary Claim	
Dispensing and administering vaccine	Professional Service Code Field – **MA** Incentive Amount Submitted Field – "Submit Administration Fee(≥ $0.01)"
Dispensing vaccine only	Submit drug cost using usual claim submission protocol
Submitting U&C Appropriately	
U&C to submit when dispensing and administering vaccine medication	Your U&C drug cost + Administration Fee

- **Reject Messaging Med B versus Med D Drug Coverage Determinations**

In order to comply with CMS guidance encouraging adoption of a new standardized procedure using structured reject "coding" in the message field, Aetna implemented this standardization, effective July 2ØØ6. This guidance and outcome resulted from retail pharmacists needing more specific reject messages in order to assist a Medicare Eligible Person.

This process has been approved by the National Council for Prescription Drug Programs (NCPDP) for two specific messages addressing rejections for (1) drugs excluded from Part D coverage as mandated by the Medicare Modernization Act; and (2) drugs that are covered under Medicare Part B for the designated Medicare beneficiary.

The codes below are returned to your pharmacy system in the free text message fields per the NCPDP standard. The codes cannot be used in the reject code field until a new claim standard is named through CMS guidance. Your software must interpret these codes from the free text message field so that the proper messages are displayed.

Reject Code	Description
A5	Not covered under Part D Law
A6	This medication may be covered under Part B and therefore cannot be covered under the Part D basic benefit for this beneficiary.

APPENDIX C: MEDICARE PART D LONG-TERM CARE

- **Medicare Part D Long-Term Care Split Billing**

The Centers for Medicare and Medicaid Services (CMS) requires that an Long-Term Care claim that is partially paid under **Medicare Part A** and partially paid by **Medicare Part D** should not pay a pharmacy two dispensing fees.

Field #	Code Value	Situation	Description	Days Supply
42Ø-DK Submission Clarification Code	19	Partial Payment under Medicare Part A	Any claim in this situation, partially paid under Medicare Part A then submitted to Medicare Part D, should now be submitted with a Submission Clarification Code of 19.	N/A

- **Medicare Part D Long-Term Care Automated Override Codes**

If a provider is enrolled within the Medicare Part D Long-Term Care network and is submitting a Qualified Long-Term Care claim (Patient Location Code of Ø3); the Provider may elect to use the following instructions for an automated claim override.

Field #	Code Value	Situation	Description	Days Supply
42Ø-DK Submission Clarification Code	Ø7	Emergency Supply	Emergency supply of non-formulary drugs & formulary w/ PA or Step Therapy Requirements	31
42Ø-DK Submission Clarification Code	14 (use value 3 for ALF)	Leave of Absence Vacation supply	Separate dispensing of small quantities of medications for take-home use allowing beneficiaries to leave facility for weekend visits, holidays, etc.	5
42Ø-DK Submission Clarification Code	15	Patient "Spit Out"	Replacement of a medication that has been "spit out"	5
42Ø-DK Submission Clarification Code	16	Emergency Box (Emergency dose)	Emergency Box (E-Box) meds for emergency treatment until standard supply can be dispensed.	5
42Ø-DK Submission Clarification Code	17	First Fill Following Emergency Box Dose	Follow-up fill after Emergency dose has been dispensed. This prescription should be filled for the full prescribed amount minus the Emergency Dosing.	Written RX Less E.R. Box Dose given
42Ø-DK Submission Clarification Code	18	LTC Admission/ Level of Care Change	Newly admitted due to clinical status change. Medications may have: been filled at retail pharmacy prior to admit; been filled prior to transfer and discontinued; not followed beneficiary to new facility due to regulatory and compliance issues and same meds reordered upon re-admit	31 Days Supply with multiple fills

- **Medicare Part D Long-Term Care Appropriate Day Supply**

Three fields have been utilized to accommodate Appropriate Day Supply (ADS) dispensing requirements; Patient Residence Code, Pharmacy Service Type and Submission Clarification Codes (SCC). Please use the following information to accurately submit claims.

Field #	Code Value	Description
42Ø-DK Submission Clarification Code	21	LTC dispensing: 14 days or less not applicable – 14 day or less dispensing is N/A due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e. vacation supply, leave of absence, ebox, spitter dose). Medication quantities are dispensed as billed,
42Ø-DK Submission Clarification Code	22	LTC dispensing: 7 days – Pharmacy dispenses medication in 7 day supplies
42Ø-DK Submission Clarification Code	23	LTC dispensing: 4 days – Pharmacy dispenses medication in 4 day supplies
42Ø-DK Submission Clarification Code	24	LTC dispensing: 3 days – Pharmacy dispenses medication in 3 day supplies
42Ø-DK Submission Clarification Code	25	LTC dispensing: 2 days – Pharmacy dispenses medication in 2 day supplies
42Ø-DK Submission Clarification Code	26	LTC dispensing: 1 day – Pharmacy or remote (multiple shifts) dispenses medication in 1 day supplies
42Ø-DK Submission Clarification Code	27	LTC dispensing: 4-3 days – Pharmacy dispenses medication in 4 day, then 3 day supplies
42Ø-DK Submission Clarification Code	28	LTC dispensing: 2-2-3 days – Pharmacy dispenses medication in 2 day, then 2 day, then 3 day supplies
42Ø-DK Submission Clarification Code	29	LTC dispensing: daily and 3-day weekend- Pharmacy or remote dispenses daily during the week and combines multiple days for dispensing weekends
42Ø-DK Submission Clarification Code	30	LTC dispensing: Per shift dispensing – Remote dispensing per shift (multiple med passes)
42Ø-DK Submission Clarification Code	31	LTC dispensing: Per med pass dispensing – Remote dispensing per med pass
42Ø-DK Submission Clarification Code	32	LTC dispensing: PRN on demand – Remote dispensing on demand as needed
42Ø-DK Submission Clarification Code	33	LTC dispensing: 7 days or less cycle not otherwise represented
42Ø-DK Submission Clarification Code	34	LTC dispensing: 14 days – Pharmacy dispenses medication in 14 day supplies
42Ø-DK Submission Clarification Code	35	LTC dispensing: 8-14 day dispensing not listed above – 8-14 day dispensing cycle not otherwise represented
42Ø-DK Submission Clarification Code	36	LTC dispensing: dispensed outside of short cycle. Claim was originally submitted to a payer other than Medicare Part D and was subsequently determined to be Part D.

Rejects may occur for the following reasons:

A Brand oral solid is submitted for greater than a 14 day supply without an appropriate SCC. In this scenario you will receive the following rejects

Reject Code	Description
7X	Plan limitations exceeded
34	M/I Submission Clarification Code

Claim is submitted with conflicting SCC short cycles of either 21 or 36 in conjunction with 22-35. In this scenario you will receive the following reject:

Reject Code	Description
34	M/I Submission Clarification Code

In order to resolve these rejects please follow these steps:

- Check the quantity submitted. Remember, a Brand oral solid can only it dispensed it 14 days or less unless an appropriate SCC is submitted.
- Use the chart above to determine which SCC applies.
- Check to make sure SCC 21 or 36 was not submitted in conjunction with SCC 22-35. SCC 21 and 36 indicate that short cycle does not apply.

- **Special Package Indicator**

You may see the following message on your paid claims:

LTC Dispensing Type Does Not Support the Packaging Type.

Field #	Code Value	Description
429-DT Special Package Indicator	1	Not Unit Dose - product is not being dispensed in special unit dose packaging.
429-DT Special Package Indicator	2	Manufacturer Unit Dose - a distinct dose as determined by the manufacturer.
429-DT Special Package Indicator	3	Pharmacy Unit Dose - 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.
429-DT Special Package Indicator	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
429-DT Special Package Indicator	5	Pharmacy Multi-drug Patient Compliance Packaging (Packaging that may contain drugs from multiple manufacturers combined to ensure compliance and safe administration)
429-DT Special Package Indicator	6	Remote device unit dose- drug is dispensed at the facility, via a remote device, in a unit of use package
429-DT Special Package Indicator	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
429-DT Special Package Indicator	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).

APPENDIX D: COMPOUND BILLING

- **Route of Administration Transition**

This appendix was added to assist in transition from the NCPDP code values formerly found in Compound Route of Administration (452-EH) in the Compound Segment to the Route of Administration (995-E2) in the Claim Segment, which only uses Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) available at http://www.snomed.org/.

High level SNOMED Value	High Level Description of Route of Administration (995-E2)
112239003	by inhalation
47056001	by irrigation
372454008	gastroenteral route
421503006	hemodialysis route
424494006	infusion route
424109004	injection route
78421000	intramuscular route
72607000	intrathecal route
47625008	intravenous route
46713006	nasal route
54485002	ophthalmic route
26643006	oral route
372473007	oromucosal route
10547007	otic route
37161004	per rectum route
16857009	per vagina
421032001	peritoneal dialysis route
34206005	subcutaneous route
37839007	sublingual route
6064005	topical route
45890007	transdermal route
372449004	dental route
58100008	intra-arterial route
404817000	intravenous piggyback route
404816009	intravenous push route