LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

BULLETIN NO. 09-07

TO: **ALL HEALTH INSURANCE ISSUERS, HEALTH MAINTENANCE ORGANIZATIONS AND THIRD-PARTY ADMINISTRATORS**

FROM: **JAMES J. DONELON, COMMISSIONER OF INSURANCE**

RE: **PHARMACY REMITTANCE ADVICE PURSUANT TO LSA-R.S. 22:1856**

DATE: **JULY 31, 2009**

Pursuant to Acts 2008, No. 755, of the Regular Session of the Louisiana Legislature, the Legislature enacted LSA-R.S. 22:1856. This law requires that each remittance advice, whether written or electronic, generated by a health insurance issuer, health maintenance organization, third-party administrator (hereinafter jointly referred to as health insurance issuer) or its agent provided to a pharmacist or his agent or a pharmacy or its agent (hereinafter jointly referred to as a pharmacist or his agent) shall be required to contain the specific information enumerated in LSA-R.S. 22:1856(C). This provision of law had an effective date of July 1, 2009.

LSA-R.S. 22:1856(E) has to be considered in conjunction with the federal law known as the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320, et seq. (hereinafter referred to either as the Health Insurance Portability and Accountability Act or HIPAA). Bulletin No. 09-07 is issued to provide guidance and assistance relative to populating the health care electronic claim payment/remittance advice transaction currently adopted by HIPAA as ASC X12 835 Version 4010A1 by utilizing current data within the National Council for Prescription Drug Program 5.1 version standards for electronic transactions as authorized by the Centers for Medicare & Medicaid Services (CMS) as HIPAA ready for HIPAA transactions and code set standards. Bulletin No. 09-07 is issued to assist health insurance issuers or their agents with the obligation to comply with LSA-R.S. 22:1856.

As stated above, Acts 2008, No. 755, was codified at LSA-R.S. 22:1856. Pursuant to LSA-R.S. 22:1856, which had an effective date of July 1, 2009, each electronic remittance advice, whether written or electronic, generated by a health insurance issuer or its agent to a pharmacist or his agent shall include the following information clearly identified and totaled for each claim listed:

1) Unique enrollee or insured identification number.
2) Patient claim number or patient account number.
3) Date that the prescription was filled.
4) National Drug Code.
5) Quantity dispensed.
6) Price submitted to the health insurance issuer or its contractor.
7) Amount paid by the health insurance issuer or its contractor.
8) Dispensing fee.
9) Provider fee.
10) Taxes.
11) Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or noncovered amount.
12) Any amount adjusted by the health insurance issuer or its contractor and the reason for adjustment.
13) Any other deduction or charge, listed separately.
14) A toll-free telephone number for assistance with the remittance advice.

Furthermore, LSA-R.S. 22:1856(E) specifically provides that no remittance advice shall contain information that violates the Health Insurance Portability and Accountability Act. Additionally, as between a health insurance issuer or its agent and a pharmacist or his agent, LSA-R.S. 22:1856(E) specifically states, in pertinent part, that "all electronic remittance advices shall follow the ANSI X12N 835 HIPAA Standard Transaction file format or any subsequent standards that are required." As such, every health insurance issuer or its agent is responsible for maintaining compliance with the submission of electronic remittance advices to a pharmacist or his agent that adheres to the current standards established by HIPAA.

In order to guide and assist health insurance issuers and pharmacists within the pharmaceutical health care industry in complying with LSA-R.S. 22:1856, the Louisiana Department of Insurance attaches to Bulletin No. 09-07 a chart entitled "Implementation Process for Complying with LSA-R.S. 22:1856." The attached chart contains the current fields and codes for providing the electronic remittance information enumerated in LSA-R.S. 22:1856. This attached chart is for guidance and assistance only, and the Louisiana Department of Insurance reiterates that it is the sole obligation of the health insurance issuer to ensure current and future compliance with the mandates of LSA-R.S. 22:1856.

For questions or further information regarding Bulletin No. 09-07, please contact the Louisiana Department of Insurance, Office of Health Insurance, by phone at (225) 219-4770.

Baton Rouge, Louisiana this 31st day of July 2009.

JAMES J. DONELON
COMMISSIONER OF INSURANCE

R.S. 22: 1856	R.S. 22: 1856	X12N - 835 4010A1 Industry Assigned Segment Name	835 LOOP	835 Reference Description	835 Name	835 Code	NCPDP 5.1 Field	NCPDP Description	NCPDP 5.1 Definition
22: 1856 C1	Unique enrollee or insured identification number.	Patient Name	2100	NM108	Identification Code Qualifier	MI			
			2100	NM109	Identification Code		302-C2 - ID	Cardholder ID (CH) and Person Code (PC) if submitted	
22:1856 C2	Patient claim number or patient account number	Claim Payment Information	2100	CLP01-1	Claim Submitter's Identifier		402-D2	NCPDP prescription/ service reference number	
22:1856 C3	Date that the prescription was filled	Service Date	2100 or 2110	DTM01 Qualifier DTM02 Date	Date/Time Qualifier	2100-232	401-D1	Date of Service	
						2110 - 472			
22:1856 C4	National Drug Code	Service Payment Information	2110	SVC01-1	Product/Service ID Qualifier		436-E1	Product/Service ID Qualifier	
				SVC01-2	Product/Service ID		407-D7	Product/Service ID	
22:1856 C5	Quantity dispensed	Service Payment Information	2110	SVC05	Paid Unit of Service		442-E7	Quantity Dispensed	
				SVC07					
				Note: Only use SVC07 if quantity paid and quantity dispensed are different					
22:1856 C6	Price submitted to the health insurance issuer or its contractor	Claim Payment Information	2100	CLP03	Total Claim Charge Amount		430-DU	Gross Amount Due	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted'(482-GE), 'Other Amount Claimed'
22:1856 C7	Amount paid by the health insurance issuer or its contractor	Claim Payment Information	2100	CLP04	Claim Payment Amount		509-F9	Total Amount Paid	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive Amount Paid' (521-FL), 'Professional Service Fee Paid' (562-J1), 'Other Amount Paid' (565-J4), less 'Patient Pay Amount' (5Ø5-F5) and 'Other Payer Amount Recognized' (566-J5).
22:1856 C8	Dispensing fee	Claim Payment Information or Service Payment Information	2100 or 2110	CAS01	Claim Adjustment Group Code				
	Note: If the submitted dispensing fee and the paid dispensing fee is included in the total gross amount due and/or the total amount paid in the NCPDP 5.1 transaction and there is a difference, then utilize the claim adjustment or service adjustment segment to report the differences.			CAS02	Claim Adjustment Reason Code				
				CAS03	Adjustment Amount				
22:1856 C9	Provider fee	Claim Payment Information or Service Payment Information	2100 or 2110	CAS01	Claim Adjustment Group Code		430-DU and 509-F9	Gross Amt Due or Total Amt Paid	If fee is included is total gross due or total amount paid, then utilize the CAS
	Note: If the submitted provider fee and the paid provider fee is included in the total gross amount due and/or the total amount paid in the NCPDP 5.1 transaction and there is a difference, then utilize the claim adjustment or service adjustment segment to report the differences.			CAS02	Claim Adjustment Reason Code				
				CAS03	Adjustment Amount				

R.S. 22: 1856	R.S. 22: 1856	X12N - 835 4010A1 Industry Assigned Segment Name	835 LOOP	835 Reference Description	835 Name	835 Code	NCPDP 5.1 Field	NCPDP Description	NCPDP 5.1 Definition
		Provider Level Adjustment		PLB01	Reference Identification				If fee is not part of NCPDP 5.1 transaction, then summary by pharmacy
	Note: If the provider fee is not included in the NCPDP 5.1 transaction, then utilize the provider level adjustment to report these provider fees summarized by provider fee.			PLB02	Date				
				PLB03-1	Adjustment Reason Code				
				PLB03-2	Reference Identification				
				PLB04	Provider Adjustment Amount				
22:1856 C10	Taxes	Claim Adjustment or Service Adjustment	2100 or 2110	CAS01	Claim Adjustment Group Code		430-DU and 509-F9	Gross Amt Due or Total Amt Paid	If taxes are a part of NCPDP 5.1, then utilize CAS
	Note: If the taxes are included in the NCPDP 5.1 transaction in the gross amount due and/or total amount paid, then utilize the claim adjustment or service adjustment to report the differences.			CAS02	Claim Adjustment Reason Code				
				CAS03	Adjustment Amount				
		Service Supplemental Amount	2110	AMT01	Amount Qualifier Code	T			When tax is part of the payable amount to the pharmacy it should be reported in this field.
				AMT02	Monetary Amount				
22:1856 C11	Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or non-covered amount	Claim Payment Information	2100	CLP05	Patient Responsibility 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.
	Note: If the submitted components of copay and the paid components of copay are included in the NCPDP 5.1 transaction and are different, then utilize the claim adjustment or service adjustment to report the differences.		2100 or 2110	CAS01	Claim Adjustment Group Code				
				CAS02	Claim Adjustment Reason Code				
				CAS03	Adjustment Amount				
22:1856 C12	Any amount adjusted by the health insurance issuer or its contractor and the reason for adjustment	Claim Adjustment or Service Adjustment	2100 or 2110	CAS01	Claim Adjustment Group Code				
	Note: If the components provided within the NCPDP 5.1 transaction as part of the total gross amount due and/or total amount paid are different, the claim adjustment or service adjustment is utilized to report these differences.			CAS02	Claim Adjustment Reason Code				
				CAS03	Adjustment Amount				
22:1856 C13	Any other deduction or charge, listed separately.	Provider Level Adjustment		PLB01	Reference Identification				
	Note: When deductions are not included in the NCPDP 5.1 transaction as part of the total gross amount due and/or total amount paid, then the provider level adjustment is utilized as a summary of these deductions.			PLB02	Date				
				PLB03-1	Adjustment Reason Code				
				PLB03-2	Reference Identification				
				PLB04	Provider Adjustment Amount				
22:1856 C14	A toll-free telephone number for assistance with the remittance advice.	Payer Contact Information	1000	PER01	Contact Function Code	CX			
				PER02	Name				
				PER03	Communication Number Qualifier	TE			
				PER04	Communication Number				