Patient Assistance Program (PAP) Data Sharing Agreement

User Guide

Version 9.5

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Confidentiality Statement

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INTRODUCTION

This *PAP Data-Sharing Agreement User Guide* provides information and instructions for the Patient Assistance Programs (PAPs) to implement and manage their information-sharing process with the Centers for Medicare & Medicaid Services (CMS). In particular, the information in this user guide will allow data exchange partners to coordinate Medicare Part D drug benefits with CMS, within the requirements of the Medicare Modernization Act (MMA).

PERIODICALLY, THE INFORMATION PROVIDED IN THIS USER GUIDE WILL CHANGE. As current requirements are refined and new processes developed, partners will be provided with new and up-to-date sections of this guide. Updated versions must replace any older versions of the guide that you might have. Please contact CMS should you have any questions regarding this user guide.

This user guide assumes a fairly comprehensive understanding of the current data sharing process. Please contact us if you find material that is unclear or if you have questions that are not addressed. All official CMS documentation regarding the data sharing process, including up-to-date record layouts and other information (such as Frequently Asked Questions) may also be obtained from the Benefits Coordination & Recovery Center (BCRC). Contact the BCRC by email at COBVA@ehmedicare.com, or call 646-458-6740.

If you would like more general information about the current data sharing process, please email vanessa.jackson@cms.hhs.gov, or call 410-786-3276. Remember to provide us with the email address, phone number and other contact information for individuals you would like to have included in the reply.

Chapter 1: Summary of Version 9.5 Changes

The following updates have been made in Version 9.5 of the PAP Data Sharing Agreement (DSA) User Guide:

The RX error code list has been updated (Section 3.4.3.2).

Chapter 2: Completing and Signing a DSA

To make the CMS relationship operational with a PAP, the potential data sharing partner and CMS have to sign and exchange completed copies of a DSA.

2.1 Process

To begin the process, PAPs first needs to complete an Attestation for Programs for Medicare Part D Enrollees Operating outside the Part D Benefit. Download the attestation from the *Pharmaceutical Manufacturer Patient Assistance Program Information* page on CMS.gov. The attestation must be completed and submitted to CMS and approved by Medicare Part D Program officials before the PAP DSA can be approved and signed by officials in the CMS Office of Financial Management. Information about the PAP Attestation and PAP DSA Agreement are available through the CMS PAP programs website, at

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PAPData.html

These are the instructions for completing a PAP DSA for signature.

1. In the first paragraph of the PAP DSA, insert all of your specific identifying information where indicated. The date that both the partner and CMS have completed the signature process will be entered here and will be the "Effective Date."

2. Enter the date that is requested on Page 3 of the PAP DSA, in Section C, 1. This is the starting date for PAP enrollment information that is entered in Field 7 on the first regular production Input File (see Page 3, below) you provide to CMS.

3. On DSA Page 7, in Section I, enter the partner's Administrative and Technical contact information.

4. Page 8, Section J: Upon receipt of a PAP DSA signed by the partner, CMS will provide the required technical contact information. This does not need to be completed to execute the Agreement.

5. In the footer starting on Page 1, and throughout the rest of the document, insert the partner's business name.

6. In the footer of the Implementation Questionnaire, insert the partner's business name.

The PAP DSA signature package consists of two documents: The PAP DSA, itself, and the PAP DSA Implementation Questionnaire. The PAP DSA partner will return three signed copies of the PAP DSA and one completed copy of the Implementation Questionnaire to CMS. One copy of the PAP DSA will be signed by CMS and returned to the partner. The CMS will not consider the PAP DSA to be in force until the partner has also provided CMS with a completed copy of the Implementation Questionnaire.

To avoid unnecessary processing delays, we strongly recommend that you use an overnight delivery service and send your PAP Data Sharing Agreement (s) and Implementation Questionnaire to:

Centers for Medicare & Medicaid Services
OFM/FSG/DMSPO
Mail Stop: C3-14-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

2.2 Updating Contact Information

Each PAP is responsible, on an ongoing basis, for communicating any changes in contact information to CMS. Failure to do so will jeopardize the partner's knowledge of, and thus compliance with, key program requirements and deadlines.

To update your contact information, please contact your Electronic Data Interchange (EDI) Representative.

Please direct questions about this guidance to vanessa.jackson@cms.hhs.gov, or call 410-786-3276.

2.3 Implementation Questionnaires

The Implementation Questionnaire asks a series of questions of the data sharing partner that helps the CMS set up the data sharing exchange process. These questions are intended to help you think through some of the issues which need to be addressed before you begin the data exchange and to assure that both the CMS and the partner are in agreement as to the operational process involved. **Partners must fill out, sign, and return a copy of the questionnaire to CMS with their signed Data Sharing Agreement.**

Chapter 3: Standard Data Files

3.1 Standard Reporting Information

Standard Data Files: The data exchanged through the DSA process are arranged in two different files (also referred to as record layouts). A data sharing partner electronically transmits a data file to CMS' Benefits Coordination & Recovery Center, referred to throughout this document as the BCRC. The BCRC processes the data in this **Input File** and, at a prescribed time, electronically transmits a Response File to the partner. The Input File is the method through which the data sharing partner will submit its covered enrollee population. In return, the BCRC will send back a **Response File** to the partner which will contain Medicare Part D enrollment information for all enrollees who also have Part D.

Current versions of the Standard Data Files immediately follow. Once again, we remind you that the information provided here will likely change from time to time. All updates to the material in this user guide are listed in Chapter 1. Please check our website for the latest edition of this user guide.

3.2 The Input and Response File Data Layouts

Input File: This is the data set transmitted from a data sharing partner to the BCRC on a monthly basis. It is used to report information regarding enrollees—individuals who are eligible for and enrolled in a PAP and receive coverage through such a plan. Full file replacement is the method used to update eligibility files. Each month's transmitted file will fully replace the previous month's file. Data sharing partners are required to continue to include coverage records for 3 years after the termination date of the coverage.

The business rules for use of the Input File immediately follow the data file layout itself.

If the partner sends more than one Input File in one day, the system will process the files without terminating, or abending, the job. If the first Input File passes its edit checks, it is processed, and a Response File is sent to the partner, per current processes. If second and subsequent input files sent that day pass their edit checks, they are added to a multiple file submissions report for review by the BCRC.

Note: If the first Input File sent is rejected, the subsequent files sent the same day are not processed automatically. In this case, the BCRC will contact the partner regarding file resubmission and processing.

Response File: This is the data set transmitted from the BCRC to the data sharing partner after the information supplied in the partner's Input File has been processed by the BCRC. It consists of the same data elements in the Input File, with corrections applied by the BCRC, indicated by disposition and edit codes which let you know what we did with the record. The Response File will also contain new information for the partner regarding the submitted enrollees, including Medicare enrollment information if a match was found.

3.2.1 PAP Input File Layout

Table 3-1: PAP Input File Layout– 249 Bytes

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Numeric	Social Security Number. Required if Medicare ID is not provided. If unavailable, fill with spaces.
2.	Medicare ID	12	10-21	Alpha-Numeric	Medicare ID, which can be the Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI). Required if SSN is not provided. If unavailable, fill with spaces.
3.	Surname	6	22-27	Text	Surname of Covered Individual – Required.
4.	First Initial	1	28-28	Alpha	First Initial of Covered Individual – Required.
5.	DOB	8	29-36	Date	Date of Birth of Covered Individual – Required. CCYYMMDD
6.	Sex Code	1	37-37	Numeric	Sex of Covered Individual – Required. 0: Unknown 1: Male 2: Female
7.	Effective Date	8	38-45	Date	Effective Date of Coverage – Required. CCYYMMDD
8.	Termination Date*	8	46-53	Date	Termination Date of Coverage – Required. CCYYMMDD Termination Date must be the last day of the calendar year for the Effective Date submitted.
9.	Filler	10	54-63	Alpha-Numeric	Unused field Fill with spaces only.
10.	Rx ID/Policy Number	20	64-83	Alpha-Numeric	Covered Individual Pharmacy Benefit ID – Required for Coverage Type V. Populate this field with all 9s if you do not have an RX ID or Policy Number.
11.	Rx Group	15	84-98	Text	Pharmacy Benefit Group Number Provide if Rx Group values assigned; otherwise, fill with spaces.

Field	Name	Size	Displacement	Data Type	Description
12.	Part D RxPCN	10	99-108	Text	Part D-specific Pharmacy Benefit Processor Control Number. Must provide if available; otherwise, fill with spaces. Cannot have special characters, except for a non-leading dash, and no leading space.
13.	Part D RxBIN	6	109-114	Text	Fill with spaces only. (Part D-specific Pharmacy Benefit International Identification Number.)
14.	Telephone Contact Number	18	115-132	Text plus "(" and ")"	Phone number to be provided for Part D Plans (PDPs) – Required.
15.	Document Control Number	15	133-147	Text	Document Control Number Assigned by PAP – Required.
16.	Coverage Type	1	148-148	Alpha-Numeric	Coverage Type Indicator – Required. U: Network (electronic, point-of-sale benefit) V: Non-Network (other type of benefit)
17.	Insurance Type	1	149-149	Alpha-Numeric	Insurance Type – Required. N: Non-qualified State Program P: PAP
18	NDC-1	11	150-160	Numeric	National Drug Code physician administered drug – Required. PAPs only
19	NDC-2	11	161-171	Numeric	National Drug Code physician administered drug If not used, populate all with zeros. PAPs only
20	NDC-3	11	172-182	Numeric	National Drug Code physician administered drug If not used, populate all with zeros. PAPs only
21	NDC-4	11	183-193	Numeric	National Drug Code physician administered drug If not used, populate all with zeros. PAPs only

Field	Name	Size	Displacement	Data Type	Description
22	NDC-5	11	194-204	Numeric	National Drug Code physician administered drug If not used, populate all with zeros. PAPs only
23.	Filler	45	205-249	Alpha-Numeric	Unused Field Fill with spaces only.

Table 3-2: PAP Input File Header Record– 249 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Will be: 'H0'
2.	PAP-ID	5	3-7	Alpha-Numeric	DSA Identifier PAPs start with "SA."
3.	Contractor Number	5	8-12	Alpha-Numeric	Will be: 'S0000'
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Filler	229	21-249	Alpha-Numeric	Unused Field Fill with spaces only.

Table 3-3: PAP Input File Trailer Record– 249 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Will be: 'T0'
2.	PAP-ID	5	3-7	Alpha-Numeric	DSA Identifier PAPs start with "SA."
3.	Contractor Number	5	8-12	Alpha-Numeric	Will be: 'S0000'
4.	File Date	8	13-20	Date	CCYYMMDD
5.	Record Count	9	21-29	Numeric	Number of records in this file. Pad with leading zeroes to make 9-digits.
6.	Filler	220	30-249	Alpha-Numeric	Unused Field Fill with spaces only.

3.2.1.1   PAP Response File Layout

Table 3-4: PAP Response File Layout– 417 Bytes

Field	Name	Size	Displacement	Data Type	Description
1.	SSN	9	1-9	Alpha-Numeric	Social Security Number
2.	Medicare ID	12	10-21	Alpha-Numeric	Medicare ID (HICN or MBI).
3.	Surname	6	22-27	Alpha-Numeric	Surname of Covered Individual
4.	First Initial	1	28-28	Alpha-Numeric	First Initial of Covered Individual

Field	Name	Size	Displacement	Data Type	Description
5.	DOB	8	29-36	Alpha-Numeric	Date of Birth of Covered Individual CCYYMMDD
6.	Sex Code	1	37-37	Alpha-Numeric	Sex of Covered Individual 0: Unknown 1: Male 2: Female
7.	Effective Date	8	38-45	Alpha-Numeric	Effective Date of PAP Coverage CCYYMMDD
8.	Termination Date*	8	46-53	Alpha-Numeric	Termination Date of PAP Coverage CCYYMMDD *Use all zeros if open-ended
9.	Filler	10	54-63	Alpha-Numeric	Unused field
10.	Rx ID	20	64-83	Alpha-Numeric	Covered Individual Pharmacy Benefit ID **Note:** This should be the value entered in the Rx ID/Policy Number field in the Input File.
11.	Rx Group	15	84-98	Alpha-Numeric	Pharmacy Benefit Group Number **Note:** Should include spaces if unknown
12.	Part D RxPCN	10	99-108	Alpha-Numeric	Part D specific Pharmacy Benefit Processor Control Number **Note:** Should include spaces if unknown
13.	Part D RxBIN	6	109-114	Alpha-Numeric	Part D specific Pharmacy Benefit Number **Note:** Should include spaces if unknown
14.	Telephone Contact Number	18	115-132	Alpha-Numeric	Phone number to be provided to Part D Plans (PDPs)
15.	Original Document Control Number	15	133-147	Alpha-Numeric	Document Control Number Assigned by PAP
16.	BCRC Document Control Number	15	148-162	Alpha-Numeric	Document Control Number Assigned by BCRC
17.	Coverage Type	1	163-163	Alpha-Numeric`	Coverage Type Indicator V: Non-Network (Other type of Benefit)
18.	Insurance Type	1	164-164	Alpha-Numeric	P: PAP
19.	Current Disposition Code	2	165-166	Alpha-Numeric	Rx Result from MBD (Action taken by BCRC).
20.	Current Disposition Date	8	167-174	Alpha-Numeric	Date of Rx Result from MBD (CCYYMMDD)

Field	Name	Size	Displacement	Data Type	Description
21.	Edit Code 1	4	175-178	Alpha-Numeric	Error Code
22.	Edit Code 2	4	179-182	Alpha-Numeric	Error Code
23.	Edit Code 3	4	183-186	Alpha-Numeric	Error Code
24.	Edit Code 4	4	187-190	Alpha-Numeric	Error Code
25.	Part D Eligibility Start Date	8	191-198	Alpha-Numeric	Earliest Date that Beneficiary is eligible to enroll in Part D – Refer to Field 46 for Part D Plan Enrollment Date CCYYMMDD
26.	Part D Eligibility Stop Date	8	199-206	Alpha-Numeric	Date Beneficiary is no longer eligible to receive Part D Benefits – Refer to Field 47 for Part D Plan Termination Date CCYYMMDD
27.	Medicare Beneficiary Date of Death	8	207-214	Alpha-Numeric	Medicare Beneficiary Date of Death CCYYMMDD
28.	Filler	56	215-270	Alpha-Numeric	Unused Field
29.	Current Medicare Part D Plan Contractor Number	5	271-275	Alpha-Numeric	Contractor Number of the current Part D Plan in which the beneficiary is enrolled
30.	Current Part D Plan Enrollment Date	8	276-283	Alpha-Numeric	Effective Date of Coverage provided by the current Medicare Part D Plan CCYYMMDD
31.	Current Part D Plan Termination Date	8	284-291	Alpha-Numeric	Termination Date of Coverage provided by the current Medicare Part D Plan CCYYMMDD
32.	Filler	18	292-309	Alpha-Numeric	Unused Field

Field	Name	Size	Displacement	Data Type	Description
33.	Dual Status Code	2	310-311	Alpha-Numeric	Dual Status Code: 00 = Eligible is not a Medicare beneficiary 01 = Eligible is entitled to Medicare- QMB only 02 = Eligible is entitled to Medicare- QMB AND full Medicaid coverage 03 = Eligible is entitled to Medicare- SLMB only 04 = Eligible is entitled to Medicare- SLMB AND full Medicaid coverage 05 = Eligible is entitled to Medicare- QDWI 06 = Eligible is entitled to Medicare- Qualifying Individuals (1) 07 = Eligible is entitled to Medicare-Qualifying Individuals (2) 08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB, QWDI or QI) with full Medicaid coverage 09 = Eligible is entitled to Medicare – Reason for Medicaid eligibility unknown 99=Eligible's Medicare status is unknown
34.	PBP	3	312-314	Alpha-Numeric	Part D Plan Benefit Package (PBP) Not applicable to PAPs.
35.	Filler	3	315-317	Alpha-Numeric	Unused Field
36.	Transaction Type	1	318	Alpha-Numeric	Actions taken from full file replacement include: 0- Add Record: New record on input file but not in existing database so record was added. 1- Delete Record: Record was not found on the input file, so the existing record was deleted. 2- Update Record: Existing record updated based on new information on input record. **Note:** If the input record contains exactly the same data as the existing record the transaction type currently on the existing record will be returned.

Field	Name	Size	Displacement	Data Type	Description
37.	Filler	18	319-336	Alpha-Numeric	Unused Field
38.	NDC-1	11	337-347	Numeric	National Drug Code physician administered drug
39.	NDC-2	11	348-358	Numeric	National Drug Code physician administered drug
40.	NDC-3	11	359-369	Numeric	National Drug Code physician administered drug
41.	NDC-4	11	370-380	Numeric	National Drug Code physician administered drug
42.	NDC-5	11	381-391	Numeric	National Drug Code physician administered drug
43.	Filler	26	392-417	Numeric	Unused Field

Table 3-5: PAP Response File Header Record– 417 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Header Indicator	2	1-2	Alpha-Numeric	Should be: 'H0'
2.	PAP-ID	5	3-7	Alpha-Numeric	DSA Identifier PAP starts with "SA."
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Filler	397	21-417	Alpha-Numeric	Unused Field

Table 3-6: PAP Response File Trailer Record– 417 Bytes

All fields required.

Field	Name	Size	Displacement	Data Type	Description
1.	Trailer Indicator	2	1-2	Alpha-Numeric	Should be: 'T0'
2.	PAP-ID	5	3-7	Alpha-Numeric	DSA Identifier PAP starts with "SA."
3.	Contractor Number	5	8-12	Alpha-Numeric	Should be: 'S0000'
4.	File Date	8	13-20	Alpha-Numeric	CCYYMMDD
5.	Record Count	9	21-29	Alpha-Numeric	Number of records in this file
6.	Filler	388	30-417	Alpha-Numeric	Unused Field

3.3 Data Type Key

3.3.1 Conventions for Describing Data Values

The following table describes the data types used by the BCRC for its external interfaces (inbound and outbound). The formatting standards used with each data type correspond to the requirements of the interface layout.

This key is provided to augment the rules prescribing the formatting of data values that are provided within the PAP Data Exchange Layout fields.

These standards should be used unless otherwise noted in the layouts.

Table 3-7: Data Type Key

Data Type/Field	Formatting Standard	Examples
Numeric	Zero through 9 (0-9) Padded with leading zeroes Populate empty fields with spaces	Numeric (5): "12345" Numeric (5): "00045" Numeric (5): " "
Alpha	A through Z Left justified Non-populated bytes padded with spaces	Alpha (12): "TEST EXAMPLE" Alpha (12): "EXAMPLE "
Alpha-Numeric	A through Z (all alpha) + 0 through 9 (all numeric) Left justified Non-populated bytes padded with spaces	Alphanum (8): "AB55823D" Alphanum (8): "MM236 "
Text	Left justified Non-populated bytes padded with spaces A through Z (all alpha) + 0 through 9 (all numeric) + special characters: Comma (,) Ampersand (&) Space ( ) Dash (-) Period (.) Single quote (') Colon (:) Semicolon (;) Number (#) Forward slash (/) At sign (@)	Text (8): "AB55823D" Text (8): "XX299Y " Text (18): "ADDRESS@DOMAIN.COM" Text (12): "800-555-1234" Text (12): "#34"
Date	Format is field specific Fill with all zeroes if empty (no spaces are permitted)	CCYYMMDD (e.g., "19991022") Open ended date: "00000000"
Filler	Populate with spaces	-
Internal Use	Populate with spaces	-

3.4 Data Management Process

The information following describes the data review processes used by the BCRC.

3.4.1 Processing Requirements

1. BCRC receives external files from a data sharing partner through a dedicated T-1 line (AT&T Global Network Services [AGNS]), HTTPS, or Secure File Transfer Protocol (SFTP).

2. The input files are checked to ensure they are in the correct format.

3. A check is performed to detect and bypass duplicate files.

4. Records are edited for required fields and data format.

5. Records received are matched to the exiting BCRC tables.

6. Transactions are created to add new records that were received, update existing records or delete records that were not received on the input file.

7. Transactions are sent to the Medicare Beneficiary Part D Database (MBD).

8. Results from MBD are used to create the response files.

9. Beneficiary Part D eligibility/enrollment information will be retrieved and added to the response files.

10. Response files are transmitted to the DSA partner.

3.4.2 Process Description

The purpose of the file process is to enable coordination of information about prescription drug benefit coverage between Medicare Part D plans and the PAPs.

In order to coordinate benefit information, data must be collected from each PAP on each of its enrollees. Submission file formats have been created for the PAP to use. This input information from a PAP will be transmitted to the BCRC where it will be edit-checked and matched against Medicare data in various eligibility databases. Once a match is found, the BCRC will be able to coordinate the beneficiary's prescription drug information with the beneficiary's Medicare Part D information, to create a record of the beneficiary's prescription drug and Medicare drug benefit coverages.

The combined drug benefit coverage information will be loaded into the Medicare Beneficiary Database (MBD). Data from the MBD will be transmitted to Part D plans. A Response File format has been created to be used to return information to the PAP. It will contain one status response record for each record initially submitted by the PAP to the BCRC. The response record will indicate if the enrollee is a Part D beneficiary, whether or not the BCRC applied the record to the MBD and if the record was not applied to the MBD, why not (e.g., the record contained errors or the record did not provide enough information about the enrollee); what Part D plan the beneficiary is in enrolled in; and other selected Part D enrollment information.

3.4.3 Disposition and Error Codes

3.4.3.1 Disposition Codes

Listed below are the disposition codes that the BCRC may provide in a Response File received by a PAP. Disposition codes provide information about the general status of the data included in a partner's input files.

Table 3-8: Disposition Codes

Disposition Codes	Description
01	Record accepted by CMS Systems, as an "Add" or a "Change" record.
SP	Transactions edit; record returned with at least one edit. Specific SP (and RX) edits are described below.
50	Record still being processed by CMS. Internal CMS use only; no partner action is required.
51	Beneficiary is not on file with CMS. Record will not be recycled. Beneficiary most likely not entitled to Medicare. Partner should reexamine Medicare beneficiary status based on information in its own files.

3.4.3.2 Error Codes (SP and RX Edits)

The BCRC will perform edit checks on partner input files and will generate the following transaction error codes, as necessary. The BCRC will supply the edit check results to the partner. The PAP will be expected to correct any errors or update any missing information on its enrollees and re-transmit the revised data on the following month's Input File submission. The SP errors that apply to records are as follows:

Table 3-9: SP Error Codes

Error Code	Description
SP 12	Invalid Medicare ID (HICN or MBI) or SSN. Field must contain alpha or numeric characters. Field cannot be blank or contain spaces.
SP 13	Invalid Beneficiary Surname. Field must contain alpha characters. Field cannot be blank, contain spaces or numeric characters.
SP 14	Invalid Beneficiary First Name Initial. Field must contain alpha characters. Field cannot be blank, contain spaces, numeric characters or punctuation marks.
SP 15	Invalid Beneficiary Date of Birth. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Day of the month must be correct. For example, if month = 02 and date = 30, the record will reject.
SP 16	Invalid Beneficiary Sex Code. Field must contain numeric characters. Field cannot be blank, contain spaces or alpha characters. Acceptable numeric characters include the following: 0 = Unknown 1 = Male 2 = Female
SP 18	Invalid Document Control (DC) Number. Field cannot be blank. The partner must assign each record a unique DC number in the event questions concerning a particular record arise and need to be addressed.

Error Code	Description
SP 24	Invalid Coverage Type. Field must contain alpha characters. Field cannot be blank or contain numeric characters. Valid values are: U: Network V: Non-network
SP 31	Invalid Coverage Effective Date. Field must contain numeric characters. Field cannot be blank, contain spaces, alpha characters or all zeros. Number of days must correspond with the particular month (CCYYMMDD).
SP 32	Invalid Coverage Termination Date. Termination Date must be equal to the last day of the calendar year for the Effective Date submitted. Cannot be spaces or zeroes (open-ended) (CCYYMMDD).
SP 62	Incoming termination date is less than effective date.

Additionally, the BCRC will provide RX-specific errors. These are standard DSA error, edit, and disposition codes used by the BCRC for processing drug records.

Table 3-10: RX-Specific Error Codes

Error Code	Description
RX 01	Missing RX ID
RX 02	Missing RX BIN. Must be 6-digit number; cannot be all the same number
RX 03	Missing RX Group Number
RX 04	Missing Group Policy Number
RX 05	Missing Individual Policy Number
RX 06	Missing or Invalid Retiree Drug Subsidy Application Number
RX 07	Medicare Beneficiary Not Enrolled in Part D
RX 08	Invalid Person Code
RX 09	Invalid Action Code
RX 10	Record not found for delete
RX 11	Record not found for update
RX 12	Invalid Supplemental Type
RX 13	If Record Type is Supplemental & Supplemental Type is "Q" or "S," Originating Contractor must be "S0000"
RX 14	Missing or invalid Toll-Free Phone Number
RX 15	If Action Code "CX," Group, BIN, or PCN required
RX 16	If Action Code "AP," Group or Policy Number required
RX 17	If Record Type is Supplemental; Supplemental Type required
RX 18	Invalid RX PCN
RX 23	NDC-1 Required (Field cannot be left blank.) (Field must be 11-character numeric.)
RX 24	Invalid NDC-2 (Field must be 11-character numeric.)
RX 25	Invalid NDC-3 (Field must be 11-character numeric.)
RX 26	Invalid NDC-4 (Field must be 11-character numeric.)
RX 27	Invalid NDC-5 (Field must be 11-character numeric.)

3.4.4 Data Processing

1. Each month the PAP submits to the BCRC an electronic Input File of all its enrollees, over the Internet using Secure FTP or HTTPS or via an existing T-1 line.

2. The BCRC edits the Input File for consistency and attempts to match the enrollees with Medicare Part D enrollment.

3. Where the BCRC determines that an enrollee on the PAP's file is a Medicare Part D beneficiary, the BCRC updates that record to the CMS Medicare Beneficiary Database (MBD). The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the Transaction Facilitation Contractor and to the Part D plan that the beneficiary is enrolled in.

4. The BCRC then submits a Response File to the PAP using the same method the Input File was submitted. This file contains a response record for each input record the PAP submitted. The response record shows if the enrollee is a Part D beneficiary; if the BCRC applied the record to the MBD; if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled, and other Part D enrollment information.

5. The PAP then examines the Response File to determine whether: The records were applied to CMS systems; the BCRC was not able to match the enrollee in the CMS systems; or the records were not applied because of errors. The PAP must correct any defective records so that when they are included in future input files they can be applied to the MBD. Errors have to be corrected because the MBD must have accurate, up-to-date partner coverage information.

6. The PAP updates its internal records regarding the Part D enrollment of its beneficiaries.

7. When the PAP submits its next monthly full Input File, it also sends corrections for all the errors found in its previous submission.

3.4.5 Business Rules for Processing

1. The monthly Input File submitted by the PAP is a full-file-replacement file. The PAP's entire file (participation record) of enrollees must be submitted each month on this file, and it must include any corrections to errors found in the previous month's file. Each month's Input File will fully replace the previous month's Input File.

2. Data-sharing partners are required to continue to include coverage records for 3 years after the termination date of the coverage.

3. A Response File will be returned to each PAP, containing a response record for each input record received. This Response File will also contain a response record for each deleted record (i.e., records that were in the previous Input File that are not in the current Input File). The disposition of the input record will be provided on its corresponding response record, including whether the record was accepted.

4. The BCRC will attempt to create one record for each enrollee record received.

5. The BCRC will not send incomplete records to the MBD.

6. On all PAP input files, the fields required are Medicare ID (HICN or MBI) or SSN, Surname, First Initial, Date of Birth, Sex Code, Network Indicator, Effective Date, Termination Date, Coverage Type Indicator, Insurance Type Indicator, and PAP ID (in both the Header and Trailer).

7. If a new Input File is received by the BCRC, it is compared with the previously submitted Input File. If it is detected that processing the new Input File will delete at least 30% of the records that were accepted in the previous submission, a "threshold error" will be generated and the file will not be processed without additional confirmation from the data-sharing partner. The PAP will be asked to verify the high number of delete records in the current submission.

Chapter 4: Working with the Data

4.1 Establishing Electronic Data Exchange

A number of methods of electronic data transmission are available when a PAP is ready to exchange files with the BCRC in test or production modes. Following is an overview of the most common. The PAP's assigned Electronic Data Interchange (EDI) Representative at the BCRC can address a PAP's specific questions and concerns.

CMS' preferred method of electronic transmission is with a PAP is via programs using either SFTP or HTTPS. We recommend either of these options for PAPs that anticipate having a relatively low volume of data to transmit.

In addition, the PAP can use Connect: Direct (formerly known as the Network Data Mover or NDM) via the CMS Electronic File Transfer (CMS EFT) protocol. This system provides a direct file transmission connection to the CMS Extranet Network and CMS' private CMSNet. This is the costliest transmission method and recommended only if a partner will be exchanging very large amounts of data with CMS. For more information on this method of electronic transmission please contact your EDI Representative at the BCRC.

Using hard media (e.g., CDs) for data management is not permitted.

4.2 Testing the Data Exchange Process

Overview: Before transmitting its first Production Input File to the BCRC, the data exchange partner and the BCRC will thoroughly test the file transfer process. Prior to submitting its initial Production Input File, the partner will submit two test Input Files to the BCRC. The first test file should simulate the partner's first full Production Input File. The BCRC will process this file and return a test initial Response File. The partner will then submit a second test input file with some new Adds, some Updates, some Deletes and corrections to errors found in the first test Response File. This should simulate the partner's ongoing monthly Input File. The BCRC will also process this test file and return a second Response File. Testing will be completed when the partner and the BCRC agree that both cycles of testing have been satisfactory.

Details: The partner and the BCRC will begin testing as soon as possible, but no later than 180 days after the date the PAP DSA is in effect. The population size of a test file will not exceed 1000 records. The partner should use "live" data even in testing (i.e., actual members and their SSNs). All administrative and technical arrangements for sending and receiving test files will be made during the "Preparatory Period." (See "Terms and Conditions" in the Data Sharing Agreement.)

Testing Records: The test file record layouts used will be the regular partner record layouts. Data provided in the test files will be kept in a test environment and will not be used to update CMS databases.

4.3 Obtaining a TrOOP Facilitation RxBIN or RxPCN

Most PAP partners **will not** need to obtain an RxBIN or RxPCN code number to enable coordination in support of the TrOOP process. This is because most PAPs will be providing assistance outside of the

Medicare Part D benefit structure, and thus will not need to be concerned with Part D's TrOOP tracking requirements.

If your PAP believes it does, or should, operate within Medicare's Part D Program, you will need to function under the terms of a different data sharing agreement. For more information, please contact Vanessa Jackson at vanessa.jackson@cms.hhs.gov.

4.4 File Processing

On a monthly basis, PAPs will transmit full file submissions in the format specified in their agreement. Full file processing requires the PAP to submit a complete file of enrollees every month. Each month's transmitted file will fully replace the previous month's file. (**Note:** PAPs are required to continue to include coverage records for 3 years after the termination date of the coverage.)

4.4.1 Contact Phone Numbers

Field 14 in the PAP Input File is labeled "Telephone Contact Number." This is the field that the PAP will use to enter the telephone number to be called if a PAP enrollee's Medicare Part D Plan wishes to contact the PAP for information about medications the enrollee/beneficiary is being provided. This contact number should be one that can take incoming calls from PDP administrative or technical staff and provide the PDP with information about the drug(s) provided by the PAP and about any out-of-pocket payments made by the beneficiary. This is a required field.

4.4.2 File Level Editing

Upon receipt of the PAP's Input File, the BCRC first performs high-level file edits to verify the format and validity of the Input File, including Header and Trailer data and record counts. The new Input File is compared with the previously submitted Input File. If it is detected that processing the new Input File will delete at least 30% of the records that were accepted in the previous submission, a "threshold error" will be generated and the file will not be processed without additional confirmation from the PAP. The PAP will be asked to verify the high number of delete records in the current submission. *With a full file replacement, the method for deleting enrollee records is to not include previously submitted enrollee records in the current Input File.* (**Note:** PAPs are required to continue to include coverage records for 3 years after the termination date of the coverage.)

The Input File is then processed at the record level. The system initially attempts to use an SSN to match to a Medicare ID (HICN or MBI) if a Medicare ID is not submitted on the input file. The system will also determine if an incoming enrollee record is an Add, Update, or Delete, or if no action will be taken.

4.4.3 Adds

Once a Medicare ID (HICN or MBI) is identified, the incoming record is compared to the CMS database to attempt to match it against previously submitted records. The initial matching criteria data set consists of the Medicare ID, Effective Date, Insurance Type, and a PAP ID. If a match of these fields cannot be made on the CMS database, the incoming record is considered an Add – a new record.

4.4.3.1 Adding New NDCs

If a PAP plan submits National Drug Codes (NDCs) that are covered at the beginning of the year but then identifies a new NDC that should be covered part-way through the year, then the plan should perform the following (for example):

- The PAP plan submits a coverage record with an effective date of 1/1/21 and a termination date of 12/31/21 with two NDCs.
- On 3/1/21, coverage for a third NDC should be added.
- On the next monthly file submission (i.e., March), the PAP will send two (2) records:
  - The original coverage record which contained the first two NDCs in NDC-1 and NDC-2 as originally reported.
  - A new coverage record with an effective date of 3/1/2021 and a termination date of 12/31/21, which includes the third NDC only, entered in the NDC-1 field because it is the only NDC reported on this record.

4.4.4 Updates

If incoming field matches indicate a record is not an Add, additional fields are compared to determine if the incoming record should be considered an Update. These additional fields include Telephone Contact Number, Coverage Type, NDC, and Termination Date. If any of these fields have changed from the previous month's submission the record is considered an Update. If the incoming record matches exactly on these additional fields, no action is taken and the PAP does not receive a response for this record.

4.4.5 Deletes

Any records contained on the previous month's file that are not included in the current submission are designated as deleted records. You will receive Delete response records in your Response File.

Deletes should only be used to remove records that never should have been included in the CMS database. All PAP Input files should contain records of enrollees whose enrollment terminated up to thirty-six months (36) prior to the first day of the month in which the current Input File is generated. This is because Medicare Part D regulations require Part D sponsors to coordinate benefits with data-sharing partners and other entities providing prescription drug coverage for a period of 3 years.

4.4.6 Errors

Records containing errors are returned to the PAP with the error code contained in the error number field on the response record. It is expected that the PAP will correct the error and resubmit the record in the next month's file.

4.4.7 Notification to the Medicare Beneficiary Database (MBD)

When processing of incoming data is complete, a file is created and transmitted to the MBD containing the Add, Update, and Delete records generated by the BCRC from the Input File submitted by the PAP. The MBD returns a file to the BCRC containing Part D enrollment information.

4.4.8 Response Files

Within 15 days of the PAP's Input File submission, the BCRC generates and transmits a Response File to the PAP. A response record is generated for each input record as well as responses indicating which records were deleted because they were not included in the current file. As a result, the PAP will receive updated Part D enrollment, regardless of whether an input record is new, updated, unchanged, or deleted.

4.5 Distinction Between Part D Eligibility and Enrollment

Some of our data sharing partners have expressed uncertainty regarding the difference between the Part D Eligibility Start and Stop Dates and Current Part D Plan Enrollment and Termination Dates they receive on their response files. While many use these terms interchangeably, these terms have distinct meanings for the CMS data exchange process. To clarify:

Part D Eligibility Start Date: Refers to the first date a beneficiary can enroll in a Part D Plan. It does not mean that the beneficiary actually has coverage, just that because they have current Part A or B coverage they may enroll in a Part D Plan.

Part D Eligibility Stop Date: Refers to the date that the beneficiary is no longer eligible to enroll in and receive coverage from any Part D Plan.

Current Part D Plan Enrollment Date: Refers to the start date of coverage for a Medicare beneficiary that is eligible, has applied for and has current coverage in a Part D Plan.

Current Part D Plan Termination Date: Refers to the date that beneficiary is no longer receiving benefits under the Part D Plan.

In the response files the BCRC sends you, the Current Part D Plan Enrollment Date provides the effective date of coverage for the Part D benefit by the specific Part D Plan listed as the **Current Medicare Part D Plan Contractor Number.** The Current Part D Plan Termination Date is the date that beneficiary is no longer receiving benefits under that Part D Plan.

These dates are the most important for our data sharing partners because they let you know whether the beneficiary has actually elected coverage under Part D and the time period in which the Part D coverage became effective. In summary, a Medicare beneficiary can be **eligible** for Part D, but unless the beneficiary is **enrolled** in a Part D Plan, the beneficiary is not receiving Part D benefits.

4.6 Contact Protocol for Data Exchange Problems

In all complex electronic data management programs, there is the potential for an occasional breakdown in information exchange. If you have a program or technical problem involving your data exchange, the first person to contact is your own EDI Representative at the BCRC. Your EDI Representative should always be sought out first to help you find solutions for any questions, issues or problems you have.

If after working with your EDI Representative, you think your problem could benefit from help at a higher level, please contact the EDI Director, Angel Pagan, at 646-458-2121. His email address is: apagan@ehmedicare.com.

The BCRC Project Director, with overall responsibility for the EDI Department, is Jim Brady. Mr. Brady can be reached at 646-458-6682. His email address is: JBrady@ehmedicare.com.

Chapter 5: Frequently Asked Questions

5.1 General Questions

Q1:   **What methods are available to me to use to communicate electronically with the BCRC in the data exchange process? Who is responsible for providing the necessary technology? Are there any alternatives?**

A1:   A PAP can submit files over the Internet via Secure File Transfer Protocol (SFTP) or HTTPS. It can also use Connect: Direct via an existing T-1 line. Using physical media such as CDs for file transfer is NOT permitted.

Q2:   **When will a PAP Partner Identification ID Code be assigned?**

A2:   The PAP ID will be assigned once the BCRC has received a signed copy of the Data Sharing Agreement (DSA) from the PAP data sharing partner. This signature copy is sent to the BCRC from CMS.

Q3:   **The BCRC – PAP data exchange is a monthly process. What is the schedule for this process? Will the data exchange happen at the beginning, middle or end of month?**

A3:   Scheduling transmission of files depends upon when the agreement is signed. There is no requirement that each PAP have the same schedule. The BCRC will work with each PAP partner during the Preparatory Period to set up a data production schedule.

Q4:   **With regard to the Administrative and Technical contacts needed for the PAP – CMS data exchange, must either or both of these contacts be PAP staff or may they be contractor staff?**

A4:   The PAP can designate whomever it wishes as the administrative and technical contacts, including contractor staff, but only a duly authorized representative of the PAP can sign the actual PAP Data Sharing Agreement.

Q5:   **What are the requirements that must be met in order to successfully complete the PAP data sharing exchange testing process?**

A5:   CMS requires the PAP partner to be able to successfully (1) submit an initial and update test Input Files that can be processed to the satisfaction of the BCRC, and; (2) receive and process a test Response File from the BCRC. The BCRC has been delegated the authority to determine whether or not the PAP partner has successfully completed the testing process to the satisfaction of CMS.

5.2 Data Elements

Q1:   **When the PAP submits a monthly full Input File, it incorporates the corrections of all the errors from the previous submission. Are we sending the full file (all PAP eligible enrollees)?**

A1:   Yes, you send a full file.

Q2:   **Should we exclude previously matched records?**

A2:   No, you should include previously matched records.

Q3:   **Are "errors" just data discrepancies (e.g., a mismatched SSN)?**

A3:   Reports of errors can include data that is defective or that contains an invalid value, such as an alpha character in a field requiring a numeric date. The reported problem could also be due to a programming error. In any case, the error will be identified in the Response File using the standard error codes described above.

Q4:   **Will we be receiving Medicare D enrollment information only, or will we be receiving information on all the other prescription coverage carried by the PAP client?**

A4:   We will provide only Medicare Part D enrollment information for your submitted PAP Program enrollees for whom the BCRC finds a match. CMS does not provide you with other (non-Medicare) insurer information; we can only provide a PAP with Medicare Part D enrollment data.

Q5:   **What field identifies the date of Medicare D enrollment?**

A5:   The Current Medicare Part D Plan Enrollment Date (Field 46 in the PAP Response File Layout) gives the most recent enrollment date in a Medicare Part D Plan.

Q6:   **What field identifies the Medicare Part D Plan?**

A6:   The Current Medicare Part D Plan Contractor Number (Field 45 in the PAP Response File Layout) identifies, by Contractor Number (not by name), the Part D Plan that the beneficiary is enrolled in.

Q7:   **Why do we have to provide a telephone contact number for the use of Part D Plans?**

A7:   If a PAP client is also enrolled in a Part D Plan, the Plan is responsible for assuring appropriate medication management for the Medicare beneficiary. Accordingly, a Part D Plan may wish to contact the PAP to inquire about the product(s) being provided to the beneficiary by the PAP. The number you provide should connect the Part D Plan to a PAP employee who is familiar with the drug(s) available through the PAP.

Q8:   **We currently do not mandate collection of an SSN from the participant (although most of our participants have an SSN). In the cases where we do not have a SSN, do we send the other information we have with the Input File? If so, do we zero fill the SSN field or leave it blank?**

A8:   The Medicare ID (HICN or MBI) is our primary identifier for matching to individuals that you submitted to determine their Medicare entitlement information. If you do not have a Medicare ID to submit you may provide an SSN. If you do not provide either of these numbers, do not attempt to submit an input record for the individual. We cannot perform our matching process without either the Medicare ID or the SSN.

Q9:   Is the Part D RxBIN and RxPCN the information that is identifying the Part D carrier or is it being used to identify other insurance as well?

A9:   This information does not identify the Part D carrier (or any other insurer). The Current Part D Plan Contractor Number (Field 45 of the PAP Response File Layout for Part D) specifically identifies the particular Part D Plan that a beneficiary is enrolled in. The Part D RxPCN and Part D RxBIN are code numbers used to electronically route Part D network pharmacy benefit utilization information. Because almost all PAPs are not involved in this "network pharmacy" billing and reimbursement process, this information will not usually apply to PAPs.

Q10:   What does the disposition code identify? Is this simply a "Yes or No" indication of coverage on the MBD?

A10:   The Current Disposition Code (Field 19) lets you know what action the BCRC has taken regarding the submitted record. For instance, if the record is not found on the CMS database the BCRC will provide the PAP data sharing partner with a disposition code indicating that circumstance. Additionally, if a record is not applied due to an error (or errors) the disposition code provides you with this information.

Q11:   What is the Plan Benefit Package code (Field 52) used for?

A11:   A Part D Plan may offer a variety of separately coded benefit packages, and the one code number for the one being used by a PDP enrolled beneficiary is placed in Field 52. However, a PAP has no need for this code, and PAPs should ignore this field. (The PAP Response File layout was adapted from a layout used in another DSA program, and this field is an unavoidable remnant.)

Q12:   Are we to send all of our PAP enrollees in input files (including non-Medicare covered individuals), or only those who have told us that they have Medicare and may be in a Part D plan?

A12:   We do not expect you to know of all your enrollees who are Part D beneficiaries. You can think of your first production Input File as a finder file. You send us all of your enrollees and we respond with a file indicating those we matched on and applied to our databases; matched on but didn't apply because of errors in the file; or did not match on and therefore are not beneficiaries. Your subsequent Input Files will include all previously identified Medicare beneficiaries receiving PAP services, and any new PAP clients and others not previously included on an Input File.

Appendix A: Acronyms

Table A-1: Acronyms

Term	Definition
AGNS	AT&T Global Network Services
ADAP	AIDS Drug Assistance Programs
AIDS	Acquired Immune Deficiency Syndrome
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
DC	Document Control (Number)
DOB	Date of Birth
DSA	Data Sharing Agreement
EDI	Electronic Data Interchange
FPL	Federal Poverty Level
HICN	Health Insurance Claim Number
HPMS	Health Plan Management System
LIS	Low Income Subsidy
MBD	Medicare Beneficiary Database
MBI	Medicare Beneficiary Identifier
MMA	Medicare Modernization Act
MSP	Medicare Secondary Payer
NDC	National Drug Code
PAP	Patient Assistance Program
PBM	Pharmacy Benefit Manager
PDP	Part D Plan
SFTP	Secure File Transfer Protocol
SPAP	State Pharmaceutical Assistance Program
SSN	Social Security Number
TrOOP	True Out-of-Pocket
VDSA	Voluntary Data Sharing Agreement

Appendix B: Previous Version Updates

Version 9.4

The RX 07 Error Code definition has been corrected (Section 3.4.3.2).

To clarify how PAPs report when they add new National Drug Codes (NDCs) for a beneficiary part-way through the year, the *Adding New NDCs* section has been updated (Section 4.4.3.1).

Version 9.3

To reflect changes implemented in May 2021 regarding the reporting of non end-of-year terminations for NDCs, the *Adding New NDCs* section has been updated (Section 4.4.3.1).

Version 9.2

To reduce the risk under the anti-kickback statute (Federal Register, 11/22/2005), PAPs provide assistance for the whole Part D coverage year (or the portion of the coverage year remaining). To support this reporting, the Termination Date submitted must be the last day of the calendar year for the Effective Date submitted. If you need to report a non end-of-year termination date for a National Drug Code (NDC) that you cover, contact the BCRC EDI Department for assistance (Section 3.2.1).

Because the Rx ID/Policy Number field of the input file is a shared field, providing different error messages depending on the record type submitted, the field description has been updated (Section 3.2.1).

Version 9.1

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields have been changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number and Rx PCN on the PAP Input File Layout (Section 3.2.1).

As part of CMS' commitment to the modernization of the Coordination of Benefits & Recovery (COB&R) operating environment, changes have been implemented to move certain electronic file transfer data exchanges to the CMS Enterprise File Transfer (EFT) protocol (Section 4.1).

Version 9.0

Starting April 5, 2021, the following changes will become effective:

To improve point-of-sale/pharmacy processing and plan payments, the criteria for several fields will be changed for users submitting primary and supplemental drug records, specifically for the Rx Insured ID Number and Rx PCN on the PAP Input File Layout (Section 3.2.1).

Starting May 2021, the following change will become effective:

To reduce the risk under the anti-kickback statute (Federal Register, 11/22/2005), PAPs provide assistance for the whole Part D coverage year (or the portion of the coverage year remaining). To support this reporting, the Termination Date submitted must be the last day of the calendar year for the Effective Date submitted. If you need to report a non end-of-year termination date for a National Drug Code (NDC) that you cover, contact the BCRC EDI Department for assistance (Section 3.2.1).

Version 8.9

The details regarding Deletes and the contacts for the data exchange escalation process have been updated (Section 4.4.5).

The PAP Response File Transaction Type field (column 318) has been clarified (Table 3-4). A business rule has been clarified to confirm that a response record is returned even if the input record is unchanged (Section 3.4.5).

Since Health and Human Services (HHS) has eliminated the regulatory requirement for health plans to obtain and use a health plan identifier (i.e., N Plan ID), references to it have been removed from this guide (Section 5.2).

Version 8.8

PAP partners are required to continue to include coverage records for 3 years after the termination date of the coverage. (Sections 3.2, 3.3.6, and 4.3.2).

Version 8.7

Effective January 2019, PAP-related OHI coverage occurrence will need to include at least one (1) associated NDC. For any issues or concerns, plans are encouraged to contact the Medicare Advantage Prescription Drug (MAPD) plan Help Desk at 1-800-927-8069, or email them at mapdhelp@cms.hhs.gov (Sections 3.2.1, 3.2.2, and 4.3.3.1).

Version 8.6

As part of the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) of 2015, all Health Insurance Claim Number (HICN) fields have been renamed as "Medicare ID" and have been configured to accept either the HICN or the new Medicare Beneficiary Identifier (MBI). Specifically, the Patient Assistance Program (PAP) data exchange systems have been modified to accept the MBI on submitted files in addition to the HICN and SSN, and they will return the MBI on Response Files under appropriate conditions.

Version 8.5

If a plan sends more than one PAP Input File in one day, the system will process the files without terminating. If the first file sent passes its edit checks, it is processed, and a response file is sent per current processes. Second and subsequent files sent the same day are added to a multiple file submissions report for review by the BCRC (Section 3.1).

Version 8.4

Contact information for the Centers for Medicare & Medicaid Services (CMS) has been updated.

Version 8.3

Reformatted document to CMS user guide standards.

Version 8.2

Section C, Part V: Using BASIS for Queries, and related references, has been removed.