DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
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Center for Medicare
Medicare Plan Payment Group

Date: July 20, 2010

To: All Part D Plan Sponsors

From: Cheri Rice, Acting Director, Medicare Plan Payment Group

Subject: Correction to Previous Guidance Titled "Revised Guidance for Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap"

This memorandum provides two important corrections to program guidance, titled "Revised Guidance for Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap", released via HPMS on July 9, 2010.

We are reissuing Attachment 1 (PDE Record Layout) and Attachment 2 (PDE Return File Layout) to reflect a correction in the order of the new data fields in the PDE. Formulary Code now correctly appears before Gap Discount Plan Override Code. The corrected file formats will be posted as Excel documents to the CSSC Operations website at the following address: www.csscoperations.com .

Also, we note one omission to the table notes on page 5 of the July 9, 2010 guidance. In addition to the fields currently indicated as not required for PACE organizations, Brand/Generic Code is also not a required field for PACE. Stated another way, there are only three fields among the new fields being implemented on January 1, 2011 that are required for PACE organizations; Date Original Claim Received, Claim Adjudication Began Timestamp, and Prescription Service Reference No.

Please direct questions regarding this guidance to PDEJan2011@cms.hhs.gov. Thank you.

Attachment 1: PDE Record Layout

Prescription Drug Event Record Layout

HDR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"HDR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Unique ID assigned by CMS.
3	FILE ID		10 - 19	X(10)	10	PDFS	Unique ID provided by Submitter. Same ID cannot be used within 12 months.
4	TRANS DATE		20 - 27	9(8)	8	PDFS	Date of file transmission to PDFS.
5	PROD TEST CERT IND		28 - 31	X(4)	4	PDFS	PROD, TEST, or CERT
6	FILLER		32 - 512	X(481)	481		SPACES

BHD RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BHD"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Assigned by CMS
4	PBP ID		16 - 18	X(3)	3	CMS	Assigned by CMS
5	FILLER		19 - 512	X(494)	494		SPACES

DET RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CLAIM CONTROL NUMBER		11 - 50	X(40)	40	CMS	Optional Field
4	HEALTH INSURANCE CLAIM NUMBER (HICN)		51 - 70	X(20)	20	CMS	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER ID	302-C2	71 - 90	X(20)	20	NCPDP	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	304-C4	91 - 98	9(8)	8	NCPDP	CCYYMMDD Optional Field
7	PATIENT GENDER CODE	305-C5	99 - 99	9(1)	1	NCPDP	1 = M 2 = F Unspecified or unknown values are not accepted
8	DATE OF SERVICE (DOS)	401-D1	100 - 107	9(8)	8	NCPDP	CCYYMMDD
9	PAID DATE		108 - 115	9(8)	8	CMS	CCYYMMDD. The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans.
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 - 127	9(12)	12	NCPDP	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 . Field will be right justified and filled with 5 leading zeroes. Applies to all PDEs submitted January 1, 2011 and after.
11	FILLER		128 - 129	X(2)	2		SPACES

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
12	PRODUCT SERVICE ID	407-D7 or 489- TE	130 - 148	X(19)	19	NCPDP	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is MMMMMDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996.
13	SERVICE PROVIDER ID QUALIFIER	202-B2	149 - 150	X(2)	2	NCPDP	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (Reported Gap Discount must = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
14	SERVICE PROVIDER ID	201-B1	151 - 165	X(15)	15	NCPDP	When Plans report Service Provider ID Qualifier = “99” - Other, populate Service Provider ID with the default value “PAPERCLAIM” defined for TrOOP Facilitation Contract. When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report embedded dashes).
15	FILL NUMBER	403-D3	166 - 167	9(2)	2	NCPDP	Values = 0 - 99.
16	DISPENSING STATUS	343-HD	168 - 168	X(1)	1	NCPDP	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
17	COMPOUND CODE	406-D6	169 - 169	9(1)	1	NCPDP	0=Not specified 1=Not a Compound 2=Compound
18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	408-D8	170 - 170	X(1)	1	NCPDP	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed 4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	442-E7	171 - 180	9(7)V999	10	NCPDP	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER		181 - 182	X(2)	2		SPACES
21	DAYS SUPPLY	405-D5	183 - 185	9(3)	3	NCPDP	0 – 999
22	PRESCRIBER ID QUALIFIER	466-EZ	186 - 187	X(2)	2	NCPDP	The type of prescriber identifier used in field 23. 01 = National Provider Identifier 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for standard format. Optional when Non-Standard Format Code = "B", "C", "P", or "X".
23	PRESCRIBER ID	411-DB	188 - 202	X(15)	15	NCPDP	Mandatory for standard format. Mandatory for non-standard format (Non-Standard Format Code = "B", "C", "P" or "X") when Prescriber ID Qualifier is present and valid, otherwise optional.

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
24	DRUG COVERAGE STATUS CODE		203 - 203	X(1)	1	CMS	Coverage status of the drug under Part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE		204 - 204	X(1)	1	CMS	A = Adjustment D = Deletion Blank = Original PDE
26	NON- STANDARD FORMAT CODE		205 - 205	X(1)	1	CMS	Format of claims originating in a non-standard format. B = Beneficiary submitted claim C = COB claim P = Paper claim from provider X = X12 837 Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE		206 - 206	X(1)	1	CMS	M= Medicare as Secondary Payer O = Out-of-network pharmacy (Medicare is Primary) Blank = In-network pharmacy (Medicare is Primary)
28	CATASTROPHIC COVERAGE CODE		207 - 207	X(1)	1	CMS	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are A = Attachment Point met on this event C = Above Attachment Point Blank = Attachment Point not met
29	INGREDIENT COST PAID	506-F6	208 - 215	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	507-F7	216 - 223	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee reported in Field 41.
31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX		224 - 231	S9(6)V99	8	CMS	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.

32	GROSS DRUG COST BELOW OUT- OF-POCKET THRESHOLD (GDCB)		232 - 239	S9(6)V99	8	CMS	Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCA. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling at or below the OOP threshold. Any remaining portion is reported in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)		240 - 247	S9(6)V99	8	CMS	Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCB. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling above the OOP threshold. Any remaining portion is reported in GDCB. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	505-F5	248 - 255	S9(6)V99	8	NCPDP	Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT		256 - 263	S9(6)V99	8	CMS	Other health insurance payments by TrOOP-eligible other payers (e.g. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP except LICS, Patient Pay Amount, and Reported Gap Discount. This amount increments the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)		264 - 271	S9(6)V99	8	CMS	Amount the plan advanced at point-of-sale due to a beneficiary's LI status. This amount increments the True Out-of-Pocket Accumulator amount.
37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)		272 - 279	S9(6)V99	8	CMS	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g. VA, TRICARE), Workers' Compensation, Auto/No-Fault/Liability Insurances.
38	COVERED D PLAN PAID AMOUNT (CPP)		280 - 287	S9(6)V99	8	CMS	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing and Over-the-Counter drugs are excluded from this field.
39	NON COVERED PLAN PAID AMOUNT (NPP)		288 -	S9(6)V99	8	CMS	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.

			295				
40	ESTIMATED REBATE AT POS		296 - 303	S9(6)V99	8	CMS	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE		304 - 311	S9(6)V99	8	CMS	The amount reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
42	PRESCRIPTION ORIGIN CODE	419-DJ	312 - 312	X(1)	1	NCPDP	Required on PDEs with DOS January 1, 2010 and forward. Valid values are: "1" = Written "2" = Telephone "3" = Electronic "4" = Facsimile On PDEs with DOS prior to January 1, 2010, "0" = Not Specified and blank are also allowed.
43	DATE ORIGINAL CLAIM RECEIVED		313 - 320	9(8)	8	CMS	Date sponsor received original claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP		321 - 346	X(26)	26	CMS	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR		347 - 355	S9(7)V99	9	CMS	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
46	TRUE OUT-OF-POCKET ACCUMULATOR		356 - 363	S9(6)V99	8	CMS	Sum of beneficiary's incurred costs (Patient Pay Amount, LICS, Other TrOOP Amount, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
47	BRAND/GENERIC CODE		364 - 364	X(1)	1	CMS	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B - Brand G - Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
48	BEGINNING BENEFIT PHASE		365 - 365	X(1)	1	CMS	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

49	ENDING BENEFIT PHASE		366 - 366	X(1)	1	CMS	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
50	REPORTED GAP DISCOUNT		367 - 374	S9(6)V99	8	CMS	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011 must be blank or zeros. This amount increments the True Out-of-Pocket Accumulator amount.
51	TIER		375 - 375	X(1)	1	CMS	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
52	FORMULARY CODE		376 - 376	X(1)	1	CMS	Indicates if the drug is on the plan's formulary. F - Formulary N - Non-Formulary Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
53	GAP DISCOUNT PLAN OVERRIDE CODE		377 - 377	X(1)	1	CMS	For future use - values TBD. Must be blank.
54	FILLER		378-512	X(135)	135	CMS	SPACES

Notes:

For any field that references NCPDP values, please refer to the appropriate NCPDP specification to ensure compliance.

All dollar fields are mandatory. If the field is not applicable, report a default value of zeroes. Since the field is a signed field, plans must utilize the appropriate overpunch signs as specified in the *NCPDP Telecommunications Standard, Version 5.1*.

BTR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"BTR"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must match BHD. Must start with 0000001.
3	CONTRACT NO		11 - 15	X(5)	5	CMS	Must match BHD
4	PBP ID		16 - 18	X(3)	3	CMS	Must match BHD
5	DET RECORD TOTAL		19 - 25	9(7)	7	CMS	Total count of DET records
6	FILLER		26 -512	X(487)	487	CMS	SPACES

TLR RECORD

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"TLR"
2	SUBMITTER ID		4 - 9	X(6)	6	CMS	Must match HDR
3	FILE ID		10 - 19	X(10)	10	PDFS	Must match HDR
4	TLR BHD RECORD TOTAL		20 - 28	9(9)	9	CMS	Total count of BHD records
5	TLR DET RECORD TOTAL		29 - 37	9(9)	9	CMS	Total count of DET records
6	FILLER		38 -512	X(475)	475	CMS	SPACES

Note:
Maximum number of detail records per file is 3 million records. If one file contains multiple batches, maximum record count applies to the cumulative total across all batches.

Attachment 2: PDE Return File Layout

HDR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD ID	1-3	X(3)	3	"HDR"
2	SUBMITTER ID	4-9	X(6)	6	Unique ID assigned by CMS.
3	FILE ID	10-19	X(10)	10	Unique ID provided by Submitter.
4	TRANS DATE	20-27	9(8)	8	Date of file transmission to PDFS.
5	PROD TEST CERT IND	28-31	X(4)	4	PROD, TEST, or CERT
6	DDPS SYSTEM DATE	32-39	9(8)	8	CCYYMMDD = DDPS file creation date
7	DDPS SYSTEM TIME	40-45	9(6)	6	HHMMSS = DDPS file creation time
8	DDPS REPORT ID	46-50	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
9	FILLER	51-512	X(462)	462	SPACES

BHD

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	CMS DESCRIPTION
1	RECORD ID	1-3	X(3)	3	"BHD"
2	SEQUENCE NO	4-10	9(7)	7	Must start with 0000001
3	CONTRACT NO	11-15	X(5)	5	Contract Number from submitted batch
4	PBP ID	16-18	X(3)	3	Plan Benefit Package (PBP) ID from submitted batch
5	DDPS SYSTEM DATE	19-26	9(8)	8	CCYYMMDD = DDPS file creation date
6	DDPS SYSTEM TIME	27-32	9(6)	6	HHMMSS = DDPS file creation time
7	DDPS REPORT ID	33-37	X(5)	5	DDPS report identifier (Always '01'). Field is right-padded with spaces.
8	FILLER	38-512	X(475)	475	SPACES

DET

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1 - 3	X(3)	3	"ACC", "REJ", or "INF"
2	SEQUENCE NO	4 - 10	9(7)	7	Must start with 0000001
3	CLAIM CONTROL NUMBER	11 - 50	X(40)	40	Optional field
4	HEALTH INSURANCE CLAIM NUMBER (HICN)	51 - 70	X(20)	20	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER ID	71 - 90	X(20)	20	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	91 - 98	9(8)	8	CCYYMMDD Optional field
7	PATIENT GENDER CODE	99 - 99	9(1)	1	1 = M 2=F
8	DATE OF SERVICE (DOS)	100 - 107	9(8)	8	CCYYMMDD
9	PAID DATE	108 - 115	9(8)	8	CCYYMMDD. The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans.
10	PRESCRIPTION SERVICE REFERENCE NO	116 - 127	9(12)	12	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 . Field will be right justified and filled with 5 leading zeroes. Applies to all PDEs submitted January 1, 2011 and after.
11	FILLER	128 - 129	X(2)	2	SPACES
12	PRODUCT SERVICE ID	130 - 148	X(19)	19	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is MMMMMDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996.

13	SERVICE PROVIDER ID QUALIFIER	149 - 150	X(2)	2	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (Reported Gap Discount must = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
14	SERVICE PROVIDER ID	151 - 165	X(15)	15	When Plans report Service Provider ID Qualifier = "99" - Other, populate Service Provider ID with the default value “PAPERCLAIM” defined for TrOOP Facilitation Contract. When Plans report Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report embedded dashes)
15	FILL NUMBER	166 - 167	9(2)	2	Values = 0 - 99.
16	DISPENSING STATUS	168 - 168	X(1)	1	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
17	COMPOUND CODE	169 - 169	9(1)	1	0=Not specified 1=Not a Compound 2=Compound

18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	170 - 170	X(1)	1	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed 4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	171 - 180	9(7)V999	10	Number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER	181 - 182	X(2)	2	SPACES
21	DAYS SUPPLY	183 - 185	9(3)	3	0 - 999
22	PRESCRIBER ID QUALIFIER	186 - 187	X(2)	2	The type of prescriber identifier used in field 23. 01 = National Provider Identifier 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for standard format. Optional when Non-Standard Format Code = "B", "C", "P", or "X".
23	PRESCRIBER ID	188 - 202	X(15)	15	Mandatory for standard format. Mandatory for non-standard format (Non-Standard Format Code = "B", "C", "P" or "X") when Prescriber ID Qualifier is present and valid, otherwise optional.
24	DRUG COVERAGE STATUS CODE	203 - 203	X(1)	1	Coverage status of the drug under Part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE	204 - 204	X(1)	1	A = Adjustment D = Deletion Blank = Original PDE

26	NON- STANDARD FORMAT CODE	205 - 205	X(1)	1	Format of claims originating in a non-standard format. B = Beneficiary submitted claim C = COB claim P = Paper claim from provider X = X12 837 Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE	206 - 206	X(1)	1	M= Medicare as Secondary Payer O = Out-of-network pharmacy (Medicare is Primary) Blank = In-network pharmacy (Medicare is Primary)
28	CATASTROPHIC COVERAGE CODE	207 - 207	X(1)	1	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are A = Attachment Point met on this event C = Above Attachment Point Blank = Attachment Point not met
29	INGREDIENT COST PAID	208 - 215	S9(6)V99	8	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	216 - 223	S9(6)V99	8	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee reported in Field 41.
31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX	224 - 231	S9(6)V99	8	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.

32	GROSS DRUG COST BELOW OUT-OF-POCKET THRESHOLD (GDCB)	232 - 239	S9(6)V99	8	Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCA. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling at or below the OOP threshold. Any remaining portion is reported in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)	240 - 247	S9(6)V99	8	Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCB. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee falling above the OOP threshold. Any remaining portion is reported in GDCB.

					This amount increments the Total Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	248 - 255	S9(6)V99	8	Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT	256 - 263	S9(6)V99	8	Other health insurance payments by TrOOP-eligible other payers (e.g. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP except LICS, Patient Pay Amount, and Reported Gap Discount. This amount increments the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)	264 - 271	S9(6)V99	8	Amount the plan advanced at point-of-sale due to a beneficiary's LI status. This amount increments the True Out-of-Pocket Accumulator amount.
37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)	272 - 279	S9(6)V99	8	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g., VA, TRICARE), Workers' Compensation, Auto/No-Fault/Liability Insurances.
38	COVERED D PLAN PAID AMOUNT (CPP)	280 - 287	S9(6)V99	8	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing, and Over-the-Counter drugs are excluded from this field.

39	NON COVERED PLAN PAID AMOUNT (NPP)	288 - 295	S9(6)V99	8	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.
40	ESTIMATED REBATE AT POS	296 - 303	S9(6)V99	8	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE	304 - 311	S9(6)V99	8	The amount reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
42	PRESCRIPTION ORIGIN CODE	312 - 312	X(1)	1	Required on PDEs with DOS January 1, 2010 and forward. Valid values are: "1" = Written "2" = Telephone "3" = Electronic "4" = Facsimile On PDEs with DOS prior to January 1, 2010, "0" = Not Specified and blank are also allowed.
43	DATE ORIGINAL CLAIM RECEIVED	313 - 320	9(8)	8	Date sponsor received original claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP	321 - 346	X(26)	26	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR	347 - 355	S9(7)V99	9	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.

46	TRUE OUT-OF-POCKET ACCUMULATOR	356 - 363	S9(6)V99	8	Sum of beneficiary's incurred costs (Patient Pay Amount, LICS, Other TrOOP Amount, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
47	BRAND/GENERIC CODE	364 - 364	X(1)	1	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B - Brand G - Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
48	BEGINNING BENEFIT PHASE	365 - 365	X(1)	1	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
49	ENDING BENEFIT PHASE	366 - 366	X(1)	1	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

50	REPORTED GAP DISCOUNT	367 - 374	S9(6)V99	8	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros. This amount increments the True Out-of-Pocket Accumulator amount.
51	TIER	375 - 375	X(1)	1	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
52	FORMULARY CODE	376 - 376	X(1)	1	Indicates if the drug is on the plan's formulary. F - Formulary N - Non-Formulary Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
53	GAP DISCOUNT PLAN OVERRIDE CODE	377 - 377	X(1)	1	For future use - values TBD. Must be blank.
54	FILLER	378 - 407	X(30)	30	SPACES
55	CMS CALCULATED GAP DISCOUNT	408 - 415	S9(6)V99	8	Amount calculated by CMS during on-line PDE editing based on data reported in the PDE.
56	PBP OF RECORD	416 - 418	X(3)	3	PBP of Record assigned by CMS during P2P Update Process. Returned only when the PBP of Record changes from the time the PDE was processed and accepted by CMS.
57	ALTERNATE SERVICE PROVIDER ID QUALIFIER	419 - 420	X(2)	2	The Alternate Service Provider ID Qualifier cross-referenced by CMS to the Service Provider ID submitted on the PDE. '01' - NPI (if Service Provider ID Qualifier submitted on PDE is '07' - NCPDP Provider ID) '07' - NCPDP Provider ID (if the Service Provider ID Qualifier submitted on PDE is '01' - NPI)

58	ALTERNATE SERVICE PROVIDER ID	421 - 435	X(15)	15	The Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE. Corresponds to the Alternate Service Provider ID Qualifier.
59	ORIGINAL SUBMITTING CONTRACT	436 - 440	X(5)	5	Contract that submitted the previously accepted PDE (in conjunction with edit 784)
60	P2P CONTRACT OF RECORD	441 - 445	X(5)	5	Contract of Record for accepted P2P PDES
61	CORRECTED HICN	446 - 465	X(20)	20	The beneficiary HICN has changed according to CMS records.
62	ERROR COUNT	466 - 467	9(2)	2	Count of errors encountered during processing
63	ERROR 1	468 - 470	X(3)	3	First error encountered during processing
64	ERROR 2	471 - 473	X(3)	3	Second error encountered during processing
65	ERROR 3	474 - 476	X(3)	3	Third error encountered during processing
66	ERROR 4	477 - 479	X(3)	3	Fourth error encountered during processing
67	ERROR 5	480 - 482	X(3)	3	Fifth error encountered during processing
68	ERROR 6	483 - 485	X(3)	3	Sixth error encountered during processing
69	ERROR 7	486 - 488	X(3)	3	Seventh error encountered during processing
70	ERROR 8	489 - 491	X(3)	3	Eighth error encountered during processing
71	ERROR 9	492 - 494	X(3)	3	Ninth error encountered during processing
72	ERROR 10	495 - 497	X(3)	3	Tenth error encountered during processing
73	EXCLUSION REASON CODE	498 - 500	X(3)	3	Sub-category reject code for an NDC Error Code of 738 identified in Errors 1-10.
74	FILLER	501 - 512	X(12)	12	SPACES

BTR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1-3	X(3)	3	"BTR"
2	SEQUENCE NO	4-10	9(7)	7	Must match BHD. Must start with 0000001.
3	CONTRACT NO	11-15	X(5)	5	Must match BHD
4	PBP ID	16-18	X(3)	3	Must match BHD
5	DET RECORD TOTAL	19-25	9(7)	7	Total count of DET records
6	DET ACCEPTED RECORD TOTAL	26-32	9(7)	7	Total count of ACC records as determined by DDPS processing
7	DET INFORMATIONAL RECORD TOTAL	33-39	9(7)	7	Total count of INF records as determined by DDPS processing
8	DET REJECTED RECORD TOTAL	40-46	9(7)	7	Total count of REJ records as determined by DDPS processing
9	FILLER	47-512	X(466)	466	SPACES

TLR

FIELD NO.	FIELD NAME	POSITION	PICTURE	LENGTH	DEFINITION / VALUES
1	RECORD ID	1-3	X(3)	3	"TLR"
2	SUBMITTER ID	4-9	X(6)	6	Must match HDR
3	FILE ID	10-19	X(10)	10	Must match HDR
4	TLR BHD RECORD TOTAL	20-28	9(9)	9	Total count of BHD records
5	TLR DET RECORD TOTAL	29-37	9(9)	9	Total count of DET records
6	TLR DET ACCEPTED RECORD TOTAL	38-46	9(9)	9	Total count of ACC records as determined by DDPS processing
7	TLR DET INFORMATIONAL RECORD TOTAL	47-55	9(9)	9	Total count of INF records as determined by DDPS processing
8	TLR DET REJECTED RECORD TOTAL	56-64	9(9)	9	Total count of REJ records as determined by DDPS processing
9	FILLER	65-512	X(448)	448	SPACES