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To: All Part D Plan Sponsors

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Subject: Prescription Drug Event (PDE) Edit Guidance
Effective January 1, 2011

In this guidance we describe on-line editing changes in the Drug Data Processing System (DDPS) effective January 1, 2011. The January 1, 2011 edits include validation of new data essential for Gap Discount implementation. As we gain experience with this new program, we expect future edit enhancements to evaluate generic cost-sharing and if necessary, to further revise gap discount editing. This document highlights significant edit changes. Any edit revisions between now and January 1, 2011 should be limited to minor wording in the edit messages.

Please forward questions about this guidance to CMS at PDEJan2011@cms.hhs.gov. Thank you.

Prescription Drug Event (PDE) Edit Guidance Effective January 1, 2011

Because the Drug Data Processing System (DDPS) processes high daily volumes we generally limit on-line editing to the data reported on individual Prescription Drug Event (PDE) record. On-line editing is the first phase of our data quality program. We evaluate data quality further in subsequent analysis of saved PDEs. This follow-on analysis of saved PDEs evaluates trends at the program and contract level and compares individual PDEs in the context of other PDEs for the same beneficiary. We publish the updated edit spreadsheet with all edits effective January 1, 2011 in Appendix One. Edit numbers with significant changes are highlighted. Any edit spreadsheet revisions between now and January 1, 2011 should be limited to minor wording in the edit messages.

The purpose of on-line PDE editing is to evaluate data on the incoming PDE and confirm that an individual PDE reports valid field-level data that is logically consistent with other data reported on the same PDE as well as data reported in selected editing tables. During on-line editing DDPS applies format rules, checks for valid values, compares data in individual fields to editing tables and evaluates logical consistency with other PDE fields. Generally we apply edits uniformly to all Part D contracts with limited exceptions for Program of All-Inclusive Care for the Elderly (PACE) Organizations and Limited Income Newly Eligible Transition (LI NET) plans. (We discuss all edits affecting PACE Organizations and LI-NET plans in separate sections at the end of this document.)

We display tables used during on-line editing in Appendix Two: DDPS Editing Tables. During on-line editing we use information maintained in two other Center for Medicare & Medicaid Servicers (CMS) systems, the Common Medicare Environment (CME) and the Health Plan Management System (HPMS) to edit Medicare Eligibility, Part D Enrollment, Low Income Cost-Sharing Eligibility, and Contract and Plan Benefit Package (PBP) values. We use data from external reference sources to validate National Drug Codes (NDCs) and Provider data. Finally we use PDE history tables built and maintained internally inside DDPS to 1.) identify duplicates, 2.) enforce business order logic (ensuring that original, adjustment or deletion and resubmission records are submitted in a logical order) and 3.) check adjustment logic. DDPS maintains a PDE history table for each year of service with the following final action information for each saved PDE: the key fields: (Date of Service, Service Provider ID, Service Provider ID Qualifier, Prescription Service Reference No and Fill Number), as well as Contract, Plan Benefit Package, Beneficiary Identifier, Adjustment/Deletion Code, and Dispensing Status Code. We will add Date Original Claim Received for any non-delete (non-LI-Net) PDE processed after January 1, 2011.

In order to implement the Gap Discount we will add three additional tables to DDPS: an abbreviated plan bid file, the Manufacturer Agreement Table and a new Food and Drug Administration (FDA) Brand/Generic table. The abbreviated plan bid table includes the plan's Initial Coverage Limit (ICL) and application of supplemental benefits in the Coverage Gap. The

Manufacturer Agreement Table is the same table CMS will publish that lists labeler codes for Manufacturers who signed the MEDICARE COVERAGE GAP DISCOUNT PROGRAM AGREEMENT. Finally, we are developing a new FDA brand/generic table to document New Drug Application (NDA) and Biologic License Application (BLA) marketing status as reported by the FDA. See Appendix Two – DDPS Edit Tables.

We organize this edit discussion in five sections. First, in Section I, we discuss edits for new fields. Section I.A outlines validity edits for new fields. Section I.B outlines Gap Discount edits subdivided into Section I.B.1 that outlines Gap Discount exclusions and Section I.B.2 that reviews Gap Discount calculations. Section I.C outlines remaining edits for new fields. Section II addresses changes necessary to align existing edits with new reporting requirements. We discuss edits specific to LI-NET in Section III. We discuss edits specific to PACE Organizations in Section IV. Finally, in Section V we review a new edit for an existing field.

I. Edits for New Fields

I.A: Edits for New Fields: Validity edits

Effective January 1, 2011 CMS adds eleven new PDE fields. DDPS applies validity edits to each of the new fields. (Please note that this editing does not apply to delete records.) We summarize format and valid values for each new field below.

Field Name	Picture	Length	Values
Date Original Claim Received	9(8)	8	CCYYMMDD
Claim Adjudication Began Timestamp	X(26)	26	CCYY-MM-DD-HH.MM.SS.MMMMMM
Total Gross Covered Drug Cost Accumulator[P] (TGCDC ACC)	S9(7)V99	9	$9,999,999.00
True Out-of-Pocket Accumulator[P] (TrOOP ACC)	S9(6)V99	8	$999,999.00
Brand/Generic Code[P]	X(1)	1	B, G
Beginning Benefit Phase[P] (BBP)	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C – Catastrophic
Ending Benefit Phase[P] (EBP)	X(1)	1	D - Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic
Tier[P]	X(1)	1	1, 2, 3, 4, 5, 6

Formulary Code[P]	X(1)	1	F, N
Reported Gap Discount[P]	S9(6)V99	8	$999,999.00
Gap Discount Plan Override Code[P]	X(1)	1	blank, additional values to be defined

[P] Not Reported for PACE Organizations

For DATE ORIGINAL CLAIM RECEIVED and CLAIM ADJUDICATION BEGAN TIMESTAMP with dates of service before January 1, 2011 CMS requires zeros of spaces. For dates of service on or after January 1, 2011, sponsors must populate a valid date or timestamp, as applicable for the field format type. These reporting rules apply uniformly, for all Drug Coverage Status Codes ('C', 'E', and 'O') and for all plan types including PACE and LI-NET. Reject edits for these two new PDE fields by date of service are displayed below.

Field Name	DOS < January 1, 2011	DOS >= January 1, 2011
DATE ORIGINAL CLAIM RECEIVED	650 (if not zeroes or spaces)	650 (if not valid date)
CLAIM ADJUDICATION BEGAN TIMESTAMP	651 (if not zeroes or spaces)	651 (if not valid timestamp)

For the remaining nine new fields there are three categories of validity edits: validity edits for covered drugs (Drug Coverage Status Code = 'C') based on date of service, validity edits for enhanced drugs and over the counter drugs (Drug Coverage Status Code = 'E' or 'O'), and validity edits for PACE Organizations which are described separately. The Table below shows reject edits for the remaining nine new PDE fields.

Field Name	Drug Coverage Status Code ='C'		Drug Coverage Status Code = 'E' or 'O' All dates of service
	DOS < Jan 1,2011	DOS >= Jan 1,2011	
TOTAL GROSS COVERED DRUG COST ACCUMULATOR (TGCDC ACC)	652 (if not zeroes or spaces)	652(must be > =0)	764(if not zeroes or spaces)
TRUE OUT-OF-POCKET ACCUMULATOR (TrOOP ACC)	653(if not zeroes or spaces)	653(must be > =0 and <= True Out-of-Pocket Threshold)	765(if not zeroes or spaces)
BRAND/GENERIC CODE	654(if not zeroes or spaces)	654(if not 'B' or 'G')	772(if not space)
BEGINNING BENEFIT PHASE	655(if not zeroes or spaces)	655(if not 'D', 'N', 'G', or 'C')	766(if not space)
ENDING BENEFIT PHASE	656(if not zeroes or spaces)	656(if not 'D', 'N', 'G', or 'C')	767(if not space)
REPORTED GAP DISCOUNT	657(if not zeroes or spaces)	657(must be > =0)	768(if not zeroes or spaces)
TIER	658(if not zeroes or spaces)	658(if not '1','2','3','4','5' or '6')	770(if not space)
FORMULARY CODE	831(if not zeroes or spaces)	831(if not 'F' or 'N')	771(if not space)
GAP DISCOUNT PLAN OVERRIDE *CODE (to be implemented at a later date.)*	659(if not zeroes or spaces)	659(if not space)	769(if not space)

Please note that DDPS rejects PDEs when the TrOOP ACC exceeds the Out-of-Pocket Threshold (edit 653). Per 1860D-2(b)(4)(A)(i), a beneficiary enters the catastrophic phase of the benefit when incurred costs for covered part D drugs in a year equal the annual out-of-pocket threshold. Because of this, the TrOOP balance should only increase up to the threshold. Once the OOP threshold is met, the beneficiary has earned the right to catastrophic benefits and no additional spending beyond the OOP threshold needs to be accumulated as TrOOP. Additionally, DDPS will issue edit 696 when the TrOOP ACC exceeds the TGCDC ACC.

I.B: Gap Discount Editing

There are two components of Gap Discount editing: exclusions and calculations.

I.B.1a: Gap Discount Exclusions

Throughout the PDE editing process we identify Gap Discount "exclusion" conditions. We reject PDEs that document a Reported Gap Discount whenever other PDE fields satisfy an exclusion condition. We summarize the Gap Discount exclusion conditions and associated edits below.

Gap Discount Exclusion Condition	PDE Data identifying exclusion condition	Edit No	Edit Description
Drugs other than Covered Drugs	DRUG COVERAGE STATUS CODE = 'E' or 'O'	657	The Reported Gap Discount is missing or invalid. Must be >= zero.
NDC for which the Manufacturer/Labeller did not sign an Agreement	Labeller Code is not present on Manufacturer Agreement Table	744	This drug is not a Part D Covered Drug because no MEDICARE COVERAGE GAP DISCOUNT PROGRAM AGREEMENT is one file for the manufacturer responsible for this labeler
Beneficiaries eligible to receive Low Income Cost-Sharing (excludes Territory Plans)	CMS tables report Low Income Eligibility for the beneficiary	865	Beneficiaries eligible for the low income cost sharing subsidy on the date of service are not eligible to receive a coverage gap discount.

Claims adjudicated at point of sale by other payers, including MSP payers and non-Part D payers who paid primary in error.	NON- STANDARD FORMAT CODE = 'C' or PRICING EXCEPTION CODE = 'M'	866	MSP and COB claims are not eligible for the coverage gap discount.
NDCs not identified as NDA or BLA by the FDA	FDA does not designate this drug as NDA or BLA; therefore it is ineligible for the coverage gap discount.	867	FDA does not designate this drug as NDA or BLA; therefore it is ineligible for the coverage gap discount.
Unspecified Service Provider ID	SERVICE PROVIDER IDQUALIFIER = '99'	868	Service Provider ID Qualifier cannot be '99' when PDE reports the coverage gap discount.
PDEs with no Coverage Gap cost, defined for this purpose as Catastrophic only	GROSS DRUG COST BELOW OUT-OF-POCKET THRESHOLD (GDCB) = 0	873	For DOS 1/1/2011 forward, if Drug Coverage Status Code is 'C' and GDBC is zero, Reported Gap Discount must be zero.
Beneficiaries the plan deems eligible to receive Low Income Cost-Sharing and extends LICS, based on the Best Available Evidence Policy	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS) > 0 and CMS tables report no Low Income Eligibility for the beneficiary (see edit 715)	874	Reported Gap Discount is > zero. Sponsor provided LICS based on Best Available Evidence. Low income beneficiaries are not eligible to receive a Coverage Gap Discount.
Compounds	COMPOUND CODE = '2'	875	Claims submitted with compound drugs are not eligible to receive the coverage gap discount.
Negative Gap Discount in 2011 and 2012	Reported Gap Discount < 0	657	The Reported Gap Discount is missing or invalid. Must be >= zero.

I.B.2: Gap Discount Calculations

In this editing step we compute the CMS Calculated Gap Discount based on data submitted on the PDE, in combination with two items the plan reports in its bid: the plan-defined Initial Coverage Limit (ICL) and the presence or absence of supplemental benefits in the Coverage Gap. Because this editing is resource intense, we limit it to PDEs that have passed all previous editing.

The Gap Discount Calculations typically consist of the three steps outlined below.

1. **Determine costs that fall in the Coverage Gap:** (using existing adjudication logic) Claims that begin and end in the coverage gap fall squarely in the gap. Straddle claims are claims that fall in two or more benefit phases. In the case of straddle claims apply dispensing fee and vaccine administration fee, to the greatest extent possible, outside the coverage gap.

2. **Determine Discount Eligible Cost:** Discount Eligible Cost is cost falling in the coverage gap, excluding supplemental benefits, dispensing fee and vaccine administration fee. The supplemental benefit is calculated first. The dispensing fee and vaccine administration fee are included in the supplemental benefit to the extent that the supplemental benefit equals or exceeds these amounts.

3. **Calculate Gap Discount:** The gap discount is 50% of Discount Eligible

The calculations to determine costs that fall in the Coverage Gap vary by benefit phase. Similarly the calculations to determine Discount Eligible Cost vary based on straddle claim status and supplemental benefits in the Coverage Gap. However, the Gap Discount calculation is always the same: Gap Discount is 50% of Discount Eligible Cost. Please see Appendix Three – Gap Discount Calculations and Appendix Four – "Gap Discount Calculation Process."

We compute the CMS Calculated Gap Discount 1.) when a claim falls squarely in the Coverage Gap or 2.) when a straddle claim that falls partially in the Coverage Gap has no supplemental benefits in the Coverage Gap. We accept or reject the PDE based on the difference (+/- rounding error), if any, between the CMS Calculated Gap Discount and the Reported Gap Discount.

Finally we document the Calculated Gap Discount on the return file we send back to the submitter. We use the following criteria to identify these PDEs:

- The Accumulator fields and the Benefit Phase fields are logically consistent.
- The Accumulator fields identify costs falling in the Coverage Gap.
- There are no supplemental benefits in the Coverage Gap. One of two conditions confirms that no supplemental benefits apply in the Coverage Gap: either the Non-Covered Plan Paid Amount (NPP) is zero or the plan bid reports that the plan has no supplemental benefits in the gap. (Since Employer Group Waiver Plans (EGWP) do not submit bids, we exclude EGWP straddle claims with non-zero NPP amounts from this series of calculations because we assume that the EGWP's supplemental benefit may apply in the Coverage Gap.)

The following edit applies to these PDEs.

Edit #	Edit Description	Edit Outcome
870	Reported Gap Discount <> CMS Calculated Gap Discount +/- 0.05.	REJ

Finally, in two separate scenarios we compute an expected range for the CMS Calculated Gap Discount and reject PDEs when the Reported Gap Discount falls above the expected range. In the first scenario the PDE reports a straddle claim with Coverage Gap costs and supplemental benefits that may apply in the Coverage Gap, either based on the plan's bid or because the plan is an EGWP. Since we can determine the Coverage Gap costs, this expected range calculation uses costs in the Coverage Gap exclusive of dispensing fee and vaccine administration fee. In other words we assume that the total amount of the supplemental benefit (reported in the Non-Covered Plan Paid Amount (NPP) falls outside the Coverage Gap.

In the second scenario, when the PDE reports illogical combinations in the Accumulators and the Benefit Phases, we also compute an expected range for the CMS Calculated Gap Discount. Since we cannot isolate costs in the Coverage Gap, we calculate the expected range based on pre-catastrophic cost, exclusive of dispensing fee and vaccine administration fee. In this scenario we assume that 1.) the total amount of pre-catastrophic drug cost is Coverage Gap Cost and 2.) supplemental benefits, if reported, do not apply in the Coverage Gap.

In both scenarios when the Reported Gap Discount falls within the expected range, we accept the PDE and return an informational edit 872 alerting the sponsor that the PDE will be subject to additional validation. We reject PDEs when the Reported Gap Discount falls above the expected range with edit 871. Subsequently, in Phase Two data quality analysis we will evaluate trends and follow up with sponsors who have high rates for edits 871 and 872.

Edit #	Edit Description	Edit Outcome
871	Reported Gap Discount exceeds 50% of the Sum of Ingredient Cost Paid, Total Amount Attributed to Sales Tax and Vaccine Administration Fee.	REJ
872	CMS could not calculate the coverage gap discount for this PDE. This PDE may be subject to additional scrutiny when the manufacturer is invoiced.	INF

I.C Other Edits for new fields

Formulary Code and Drug Coverage Status Code: Both formulary and non-formulary drugs may be reported with Drug Coverage Status Code = 'C'. Typically drugs that are covered by an exception process are non-formulary drugs. Both formulary and non-formulary drugs may be applicable drugs and hence eligible for the Gap Discount. Initially in January 1, 2011, we will not edit the relationship between Formulary Code and Drug Coverage Status Code. We include this clarification because we have received inquiries from the industry. Valid combinations for Formulary Code and Drug Coverage Status Code are below.

Formulary Code	Drug Coverage Status Code
'F'	'C'
'N'	'C'

Accumulators and Benefit Phases: During on-line editing DDPS rejects PDEs when 1.) the TrOOP ACC exceeds the Out-of-Pocket Threshold (edit 653), 2,) when the TrOOP ACC exceeds the TGCDC ACC (edit 696) or when 3.) the Beginning Benefit Phase and Ending Benefit Phase values are illogical, because the Ending Benefit Phase should be a benefit phase equal to or later in the benefit than the Beginning Benefit Phase (edit 786). The rationale for edit 786 is that spending for a Part D covered drug advances a beneficiary forward in the benefit. In other words, within a single PDE, the Ending Benefit Phase cannot precede the Beginning Benefit Phase because a beneficiary cannot move backwards in the benefit within a single PDE. DDPS applies edit 786 in the following scenarios:

Beginning Benefit Phase (BBP)	Ending Benefit Phase (EBP)
Initial Coverage Period – N, or Coverage Gap - G, or Catastrophic - C	Deductible - D
Coverage Gap – G, or Catastrophic - C	Initial Coverage Period –N
Catastrophic - C	Coverage Gap - G

Edit #	Edit Description	Edit Outcome
653	The True Out-of-Pocket Accumulator is missing or invalid. For DOS 1/1/2011 forward, must be >= zero. For DOS 1/1/2011 prior, must be zeros or spaces. Cannot exceed the program level OOP Threshold.	REJ
696	True Out-of-Pocket Accumulator cannot be greater than Total Gross Covered Drug Cost Accumulator.	REJ
786	Beginning and Ending Benefit Phase combination is invalid.	REJ
787	Beginning and Ending Benefit Phase combination does not match the True Out-of-Pocket Accumulator and/or Total Gross Covered Drug Cost Accumulator.	INF

We anticipate that invalid Beginning and Ending Benefit Phase combinations (edit 787) will occur infrequently. In subsequent analysis of saved PDEs we will review trends associated with edit 787 at the beneficiary, contract and program level. Our beneficiary level review will include "report as administered" scenarios as well as the impact of Financial Information Reporting (FIR) transactions.

NDC editing – Part D Covered Drugs: In the event that a Manufacturer does not sign an agreement with the Secretary, CMS will not cover the drugs with the Manufacturer's labeler codes designated by the FDA as NDA and BLA. We modify NDC editing to reject drugs with FDA designation of NDA or BLA in the event that a Manufacturer does not sign an agreement with the Secretary to participate in the Gap Discount Program. We use a two step process to identify and reject PDEs with NDCs that meet these conditions. First we identify any PDE with an NDC labeler code not listed on the Manufacturer Agreement Table. Then we check the FDA designation for the individual NDC. We will reject NDCs with FDA designation of NDA or BLA and no Manufacturer Agreement with reject edit 744.

II. Changes to Existing Edits

When necessary we make edit updates to align existing edits with new requirements. For example, reasons to change existing edits include revised field length, record layout changes, and discontinued fields.

Edit 612-PRESCRIPTION SERVICE REFERENCE NUMBER: Effective January 1, 2011 CMS will expand PRESCRIPTION SERVICE REFERENCE NO to twelve positions (See guidance published in HPMS on July 9, 2010 with subject line "Revised Guidance for Prescription Drug Event (PDE) Record Changes Required to Close the Coverage Gap" for additional information.) This change affects any PDE submitted on or after January 1, 2011, regardless of date of service. Although the edit message remains unchanged, CMS will modify implementation of existing edit 612 to ensure that the field length for PRESCRIPTION SERVICE REFERENCE NO is twelve positions for any PDE submitted on or after January 1, 2011.

Edit 641-Filler Space: Because PRESCRIPTION SERVICE REFERENCE NO expands to a twelve position field, adjacent fields, including filler fields, shift three positions to the right. Edit 641 validates that the filler fields on the PDE record are blank. Although the edit message remains unchanged, CMS will modify implementation of existing edit 614 to ensure that filler fields in positions 128-129, 181-182 and 378-512 are blank for any PDE submitted on or after January 1, 2011.

Edit 617-DISPENSING STATUS CODE: CMS no longer supports Partial and Complete Dispensing Status for dates of service on or after January 1, 2011. Valid values for dates of service before January 1, 2011 are 'blank' – complete, 'P' – Partial, and 'C' – Completion of Partial Fill. CMS will modify existing edit 617 to reflect that 'Blank' is the only valid value for dates of service on or after January 1, 2011.

Edit #	Edit Description	Edit Outcome
617	The Dispensing Status is invalid. For DOS 1/1/2011 prior, the Dispensing Status must be either a blank or 'P' or 'C'. For DOS 1/1/2011 forward, the Dispensing Status must be blank.	REJ

Edit 629-CATASTROPHIC COVERAGE CODE: Beginning in January, 2011, reporting is optional. Therefore there is no change in the validity edit for CATASTROHIC COVERAGE CODE. Valid values for all dates of service remain as 'blank', 'A' – Attachment Point, and 'C' – Catastrophic.

Edits 690 and 692-Cost Balancing Edits: We add Reported Gap Discount in these edit calculations. We also modify edit 690 for dates of service on or after January 1, 2011 because sponsors no longer report the value of 'P' in DISPENSING STATUS CODE.

Edit 693-DISPENSING STATUS CODE: We discontinue edit 693 for dates of service on or after January 1, 2011 because sponsors no longer report the value of 'C' in DISPENSING STATUS CODE

Edit updates that replace CATASTROPHIC COVERAGE CODE with Accumulator values:

In 2011 the TGCDC ACC and the TrOOP ACC replace the CATASTROPHIC COVERAGE CODE. We retain existing edits using CATASTROPHIC COVERAGE CODE for dates of service before January 1, 2011. Although sponsors have the option to continue reporting CATASTROPHIC COVERAGE CODE in 2011, we cannot use an optional field in editing. Therefore we revise edits using CATASTROPHIC COVERAGE CODE by replacing it with the TrOOP ACC value. We identify pre-catastrophic costs with the following calculation to confirm that TrOOP remains below the OOP Threshold throughout processing of the individual claim:

TrOOP ACC + Delta TrOOP** <=OOP Threshold

Where Delta TrOOP=PATIENT PAY AMOUNT+OTHER TROOP+REPORTED GAP DISCOUNT+LICS AMOUNT

We use TrOOP ACC = OOP Threshold exclusively in place of CATASTROPHIC COVERAGE CODE = 'C' to identify catastrophic costs.

Currently the Low Incomes Cost-Sharing (LICS) edits (717-721) and the cost validation edits (670 through 674) use CATASTROPHIC COVERAGE CODE.

The table below summarizes the LICS edit changes. The LICS cost-sharing edits identify Low Income beneficiary cost-sharing. (For example, in 2010 maximum pre-catastrophic cost-sharing for the Category 2 LI beneficiary is $3.10 and catastrophic cost-sharing is $0.)

Edit #	Condition*	Implementation for DOS < January 1, 2011	Implementation for DOS on/after January 1, 2011
717, 718, 718, 719	Pre-catastrophic Cost-Sharing	CATASTROPHIC COVERAGE CODE = 'blank'	TrOOP ACC< OOP Threshold and TrOOP ACC + Delta TrOOP** <=OOP Threshold
720, 721	Catastrophic Cost-Sharing	CATASTROPHIC COVERAGE CODE = 'C'	TrOOP ACC = OOP Threshold

* Applies to Covered Drugs Only; Drug Coverage Status Code = 'C'

** Delta TrOOP=PATIENT PAY AMOUNT+OTHER TROOP+ REPORTED GAP DISCOUNT+LICS AMOUNT

The cost validation edits (670 through 674) ensure a logical relationship between pre-catastrophic and catastrophic costs and benefit phase. The table below summarizes these edits.

Edit #	Condition*	Implementation for DOS < January 1, 2011	Implementation for DOS on/after January 1, 2011
670	GDCB must be > 0	CATASTROPHIC COVERAGE CODE = 'blank'	TrOOP ACC < OOP Threshold
671	GDCA must = 0	CATASTROPHIC COVERAGE CODE = 'blank'	TrOOP ACC + Delta TrOOP** < OOP Threshold
672	GDCB must be > 0	CATASTROPHIC COVERAGE CODE = 'A'	N/A
673	GDCA must be > 0	CATASTROPHIC COVERAGE CODE = 'C'	TrOOP ACC = OOP Threshold
674	GDCB must = 0	CATASTROPHIC COVERAGE CODE = 'C'	TrOOP ACC = OOP Threshold

* Applies to Covered Drugs Only; Drug Coverage Status Code = 'C'

**Delta TrOOP=PATIENT PAY AMOUNT+OTHER TROOP+
REPORTED GAP DISCOUNT+LICS AMOUNT

III. Limited Income Newly Eligible Transition (LI-NET) edits

Part D payment reconciliation for an LI NET plan is based upon DATE ORIGINAL CLAIM RECEIVED as opposed to dates of service within a benefit year. As a result of this difference, there are two LI NET specific requirements for the DATE ORIGINAL CLAIM RECEIVED field that are effective January 1, 2011.

- DATE ORIGINAL CLAIM RECEIVED must be populated for all LI NET PDEs, including delete PDEs, regardless of the date of service. If the DATE ORIGINAL CLAIM RECEIVED is not populated with a valid value, DDPS rejects the PDE with validity edit 650.

- DATE ORIGINAL CLAIM RECEIVED on all LI NET adjustment and deletion PDEs must be the same as the DATE ORIGINAL CLAIM RECEIVED that was reported on the previously saved PDE. (Typically the previously saved PDE is an original PDE. However, since a plan can submit two consecutive adjustments, the same logic applies if the previously saved PDE is an adjustment PDE.) DDPS will reject the PDE with edit 664 when DATE ORIGINAL CLAIM RECEIVED on the incoming adjustment or delete PDE does not match the DATE ORIGINAL CLAIM RECEIVED on the stored PDE.

The above requirements are in addition to the new editing and calculating requirements for the Gap Discount program that are discussed in this guidance.

IV. PACE

As stated in the April 30, 2010 HPMS entitled, "Medicare Coverage Gap Discount Program beginning in 2011", PACE plans that have no coverage gap by statutory design are excluded from the Discount Program.

CMS has developed new validity edits that are specific to PACE organizations. The validity edits are effective January 1, 2011 and apply to all dates of service. In addition to the edits below, edits 650 and 651 can apply to PACE organizations.

Field Name	Reject Edit Code
TOTAL GROSS COVERED DRUG COST ACCUMULATOR	811
TRUE OUT-OF-POCKET ACCUMULATOR	812
BEGINNING BENEFIT PHASE	813
ENDING BENEFIT PHASE	814
REPORTED GAP DISCOUNT	815
TIER	816
GAP DISCOUT PLAN OVERRIDE CODE (to be implemented at a later date)	817
FORMULARY CODE	818
BRAND/GENERIC CODE	819

Section I.C discusses NDC editing of Part D covered drugs. Edit 744 applies to all organizations, including PACE.

Section II discusses changes to existing edits. The changes to the edits for PRESCRIPTION SERVICE REFERENCE NUMBER, Filler space, and DISPENSING STATUS CODE apply to PACE organizations. All other changes to existing edits do not apply to PACE organizations.

V. New edit using Existing Fields

Effective with dates of service on or after January 1, 2011, we introduce a new edit 675 – "On PDEs that straddle the Out-of-Pocket threshold where LICS is > than zero, CPP must be 95% of GDCA." The purpose of this edit is to evaluate LICS amounts reported in PDEs for a subset of claims that straddle the OOP Threshold. Edit 675 applies for Part D Covered Drugs for Low Income Eligible beneficiaries when the claim

- begins in the Coverage Gap (as defined by the plan's ICL) and ends in the Catastrophic Phase of the benefit, and
- has catastrophic coinsurance (i.e. in 2011 GDCA is greater than 126.00)

Since the COVERED PLAN PAID AMOUNT (CPP) for LICS beneficiaries in the Coverage Gap is zero, the CPP amount for these specific straddle claims should be based only on catastrophic costs which we can calculate as 95% of GDCA. In previous analysis we have observed that plans sometimes omit the CPP calculation for catastrophic costs and report the catastrophic CPP amount in the LICS amount. Edit 675 rejects PDEs when CPP is less than expected and the calculated CPP amount is reported in the LICS field. For catastrophic low-income beneficiaries with catastrophic cost (i.e. GDCA > $126.00) the catastrophic portion of LICS will be 5% of the catastrophic cost; the remaining catastrophic cost will be reported in CPP. And since there is no CPP in the coverage gap for an LI beneficiary, we assume an error when CPP is less than 95% of catastrophic costs.

Appendix One - DRUG DATA PROCESSING SYSTEM and DRUG BENEFIT CALCULATOR (DDPS/DBC) Transaction & Validation Edits

Error #	Edit Category	Data Element to be Edited	Message to be Reported	Comments/Rationale	Edit Applicable (Y/N)						Failure Outcome (Reject, Informational, or Update)
					Standard	X12	Paper	Bene-Submitted	PACE	Fallback	
603	M/I	Health Insurance Claim (HIC) Number	The HICN is missing. Must not be blank.		Y	Y	Y	Y	Y	Y	Reject
604	M/I	Cardholder ID	The Cardholder ID is missing.		Y	Y	Y	Y	Y	Y	Reject
605	M/I	Patient Date of Birth (DOB)	The DOB is an invalid date. Dates must be in CCYYMMDD format.	DOB is optional. If Plans choose to report DOB, the format must be correct. Matching is done on Month and Year only, Day is disregarded. If no DOB is to be provided, zeros or spaces should be used to populate this field.	Y	Y	Y	Y	Y	Y	Reject
606	M/I	Patient Gender	The Gender is missing or invalid. The Gender must be either '1' or '2'.		Y	Y	Y	Y	Y	Y	Reject
607	M/I	Date of Service (DOS)	The DOS is missing or invalid. DOS must be in CCYYMMDD format and be a valid date.		Y	Y	Y	Y	Y	Y	Reject
608	M/I	Date of Service (DOS)	The DOS must be on/after 1/1/2006.	-	Y	Y	Y	Y	Y	Y	Reject
609	M/I	Date of Service (DOS)	DOS must be on or before today's date.		Y	Y	Y	Y	Y	Y	Reject
610	M/I	Paid Date	The Paid Date is missing. Must not be blank for Fallback Plans.	Paid Date is optional for non-Fallback Plans. If Paid Date is not provided, zeros or spaces should be used to populate this field.	N	N	N	N	N	Y	Reject
611	M/I	Paid Date	The Paid Date is an invalid date in CCYYMMDD format.	If non-Fallback Plans choose to report Paid Date, format must be correct. DDPS will reject all date fields with invalid date format.	Y	Y	Y	Y	Y	Y	Reject
612	M/I	Prescription/ Service Reference Number	The Prescription Number/Service Reference Number is missing or invalid. Prescription Number/Service Reference Number must be numeric.		Y	Y	Y	Y	Y	Y	Reject
613	M/I	Product/ Service ID	The NDC code is missing.		Y	Y	Y	Y	Y	Y	Reject

614	M/I	Service Provider ID Qualifier	The Service Provider ID Qualifier is missing or invalid. Service Provider ID Qualifier must be equal to '01' - NPI or '06' - UPIN or '07' - NCPDP or '08' - State License or '11' - TIN or '99' - Other.	Service Provider ID Qualifier must be '01' - NPI or '07' - NCPDP on standard claim.	Y	Y	Y	Y	Y	Y	Reject
615	M/I	Service Provider ID	The Service Provider ID is missing or invalid.	Both NPI and NCPDP numbers are validated.	Y	Y	Y	Y	Y	Y	Reject
616	M/I	Fill Number	The Fill Number is missing or invalid. The Fill Number must be equal to a value between 0 and 99.		Y	Y	Y	Y	Y	Y	Reject
617	M/I	Dispensing Status	The Dispensing Status is invalid. For DOS prior to 1/1/2011, the Dispensing Status must be either a blank or 'P' or 'C'. For DOS 1/1/2011 and forward, the Dispensing Status must be blank.		Y	Y	Y	Y	Y	Y	Reject
618	M/I	Compound Code	Compound Code is missing or invalid. The Compound Code must be equal to 0, 1 or 2.		Y	Y	Y	Y	Y	Y	Reject
619	M/I	DAW/Product Selection Code	The DAW/Product Selection Code is missing or invalid. The DAW/Product Selection Code must be equal to a value between ‘0’ and ‘9’.		Y	Y	Y	Y	Y	Y	Reject
620	M/I	Quantity Dispensed	The Quantity Dispensed is missing or invalid. The Quantity Dispensed must be greater than or = 0.001.		Y	Y	Y	Y	Y	Y	Reject
621	M/I	Days Supply	The Days Supply is missing or invalid. The value must be a value between 0 and 999 days.		Y	Y	Y	Y	Y	Y	Reject
622	M/I	Prescriber ID Qualifier	Prescriber ID Qualifier is missing.	Applies only to standard format claims.	Y	N	N	N	Y	Y	Reject
623	M/I	Prescriber ID Qualifier	Prescriber ID Qualifier is invalid. The Prescriber ID Qualifier must be equal to '01' - NPI or '06' - UPIN or '08' - State License or '12' - DEA.	If present, must be a valid value.	Y	Y	Y	Y	Y	Y	Reject

624	M/I	Prescriber ID	The Prescriber ID is missing. Must not be blank.	Applies on all standard format claims and on non-standard format claims when Prescriber ID Qualifier is present and valid.	Y	Y	Y	Y	Y	Y	Reject
625	M/I	Drug Coverage Status Code	The Drug Coverage Status Code is missing or invalid. Valid values are ‘C’, ‘E’ & ‘O’.		Y	Y	Y	Y	Y	Y	Reject
626	M/I	Adjustment/ Deletion Code	The Adjustment Code is invalid. Valid Values are ‘A’ for Adjustment and ‘D’ for Deletion, or 'blank'.		Y	Y	Y	Y	Y	Y	Reject
627	M/I	Non-Standard Format Code	The Non-Standard Format Code is invalid. Valid values are ‘blank’, ‘B’, ‘X’, ‘P’, 'S', or 'C'		Y	Y	Y	Y	Y	Y	Reject
628	M/I	Pricing Exception Code	The Pricing Exception Code is invalid. Valid values are ‘blank’, ‘O’, or ‘M’.		Y	Y	Y	Y	Y	Y	Reject
629	M/I	Catastrophic Coverage Code	The Catastrophic Coverage Code is invalid. Must be Blank, ‘A’, or ‘C’.		Y	Y	Y	Y	Y	Y	Reject
630	M/I	Ingredient Cost Paid	The Ingredient Cost Paid is missing or invalid. The Ingredient Cost Paid must be >= zero.	Drug cost must always be greater than zero. This requirement also applies to OTC drugs funded by administrative costs.	Y	Y	Y	Y	Y	Y	Reject
631	M/I	Dispensing Fee Paid	Dispensing Fee Paid is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
632	M/I	Total Amount Attributed to Sales Tax	Sales Tax is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
633	M/I	Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB)	GDCB is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
634	M/I	Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)	GDCA is missing or invalid, must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
635	M/I	Patient Pay Amount	The Patient Pay Amount is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
636	M/I	Other TrOOP Amount	Other TrOOP Amount is missing or invalid, must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
637	M/I	Low Income Cost-sharing Subsidy Amount (LICS)	The LICS value is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject

638	M/I	Patient Liability Reduction due to Other Payers (PLRO)	PLRO is missing or invalid. Must be numeric.		Y	Y	Y	Y	Y	Y	Reject
639	M/I	Covered D Plan Paid Amount (CPP)	CPP is missing or invalid. Must be >= zero.		Y	Y	Y	Y	Y	Y	Reject
640	M/I	Non-covered Plan Paid Amount (NPP)	NPP is missing or invalid. Must be numeric.		Y	Y	Y	Y	Y	Y	Reject
641	M/I	Filler Fields, positions 128-129, 181-182, and 378-512.	Filler fields must be blank.	Change from filler field positions 125-126 and 308-512 to 128-129, 181-182, and 378-512. Effective for all PDEs submitted 1/1/2011 and forward.	Y	Y	Y	Y	Y	Y	Reject
642	M/I	Non-Standard Format Code, Date of Service	State-to-Plan PDEs are not allowed with dates of service after March 31, 2006		Y	Y	Y	Y	Y	Y	Reject
643	M/I	Non-Standard Format Code, Drug Coverage Code	State-to-Plan PDEs are not allowed with non-covered drugs.	Only PDEs with "C" drugs may be considered for State-to-Plan Reconcilation. Applies only to State-to-Plan PDEs.	Y	Y	Y	Y	Y	Y	Reject
644	M/I	Non-Standard Format Code, Service Provider ID Qualifier	Service Provider ID Qualifier must be '07' for State-to-Plan PDEs.	The Service Provider ID must be an NCPDP code for State-to-Plan PDEs. Applies only to State-to-Plan PDEs.	Y	Y	Y	Y	Y	Y	Reject
645	M/I	Non-Standard Format Code, Service Provider ID Qualifier, Service Provider ID	Service Provider ID '5300378' allowed only for State-to-Plan PDEs.	Service Provider code '5300378' is reserved for use in State-to-Plan PDEs only.	Y	Y	Y	Y	Y	Y	Reject
646	M/I	Estimated Rebate at Point of Sale	Estimated Rebate at Point of Sale amount is missing or invalid. For DOS effective January 1, 2008 and forward, must be >= zero. For DOS prior to January 1, 2008, must be zero or spaces.		Y	Y	Y	Y	Y	Y	Reject
647	M/I	Vaccine Administration Fee	Vaccine Administration Fee Amount is missing or invalid. For DOS effective January 1, 2008 and forward, must be >= zero. For DOS prior to January 1, 2008, must be zero or spaces.		Y	Y	Y	Y	Y	Y	Reject

648	M/I	Prescription Origin Code	The Prescription Origin Code is invalid. Valid values are blank, “0”, “1”, “2”, “3”, and “4”.	For DOS effective January 1, 2010 and forward. This edit only applies to non-standard format PDEs and standard format PDEs for refills (Fill Number not = '00').	Y	Y	Y	Y	Y	Y	Reject
649	M/I	Prescription Origin Code	The Prescription Origin Code is invalid. Valid values for original fill standard formats are “1”, “2”, “3”, and “4”.	Original fill PDEs are identified as having Fill Number ='00'. This edit only applies to PDEs with DOS effective January 1, 2010 and forward.	Y	N	N	N	Y	Y	Reject
650	M/I	Date Original Claim Received	The Date Original Claim Received is missing or invalid. For DOS 1/1/2011 and forward, must be a valid date in CCYYMMDD format. Cannot be a future date or less than the Date of Service. For DOS prior to 1/1/2011, must be zeros or spaces.	Required on all LI NET PDEs, for any DOS.	Y	Y	Y	Y	Y	Y	Reject
651	M/I	Claim Adjudication Began Timestamp	The Claim Adjudication Began Timestamp is missing or invalid. For DOS 1/1/2011 and forward, must be a valid timestamp in the CCYY-MM-DD-HH.MM.SS.MMMMMM format. Cannot be a future date or < DOS. For DOS prior to 1/1/2011, must be zeros or spaces.		Y	Y	Y	Y	Y	Y	Reject
652	M/I	Total Gross Covered Drug Cost Accumulator	The Total Gross Covered Drug Cost Accumulator is missing or invalid. For DOS 1/1/2011 and forward, must be >= zero. For DOS prior to 1/1/2011, must be zeros or spaces.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
653	M/I	True Out-of-Pocket Accumulator	The True Out-of-Pocket Accumulator is missing or invalid. For DOS 1/1/2011 and forward, must be >= zero. For DOS prior to 1/1/2011, must be zeros or spaces. Cannot exceed the program level OOP Threshold.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject

654	M/I	Brand/Generic Code	The Brand/Generic Code is missing or invalid. Valid values are 'B' for brand or 'G' for generic.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
655	M/I	Beginning Benefit Phase	The Beginning Benefit Phase is missing or invalid. For DOS 1/1/2011 and forward, valid values are 'D' for Deductible, 'N' for Initial Coverage Period, 'G' for Coverage Gap or 'C' for Catastrophic. For DOS prior to 1/1/2011, must be blank.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
656	M/I	Ending Benefit Phase	The Ending Benefit Phase is missing or invalid. For DOS 1/1/2011 forward, valid values are 'D' for Deductible, 'N' for Initial Coverage Period, 'G' for Coverage Gap or 'C' for Catastrophic. For DOS prior to 1/1/2011, must be blank.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
657	M/I	Reported Gap Discount	The Reported Gap Discount is missing or invalid. Must be >= zero.	Conditionally required on PDEs with DOS 1/1/2011 and forward. On PDEs with DOS prior to 1/1/2011, or on PDEs where the Gap Discount does not apply, must be zeros or spaces. Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
658	M/I	Tier	The Tier is missing or invalid. For DOS 1/1/2011 and forward, must be a numeric value from 1-6. For DOS prior to 1/1/2011, must be blank.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
659	M/I	Gap Discount Plan Override Code	The Gap Discount Plan Override Code is invalid. Must be blank.	Future use. Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject

660	Adj/Del	Adjustment/ Deletion Code, Contract Number, Plan Benefit Package ID, HIC number, Service Provider ID, Service Provider ID Qualifier, Prescription/ Service Reference Number, Date of Service, Fill Number, and Dispensing Status	The Adjustment/Deletion PDE does not match the existing PDE record.	Please check the Contract No, PBP ID, HICN, Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status. All nine (9) fields noted must match the existing PDE record.	Y	Y	Y	Y	Y	Y	Reject
661	Adj/Del	Adjustment/ Deletion Code, Contract Number, Plan Benefit Package ID, HIC number, Service Provider ID, Service Provider ID Qualifier, Prescription/ Service Reference Number, Date of Service, Fill Number, and Dispensing Status	Cannot adjust a deleted record. Existing PDE has already been deleted.		Y	Y	Y	Y	Y	Y	Reject
662	Adj/Del	Adjustment/ Deletion Code, Contract Number, Plan Benefit Package ID, HIC number, Service Provider ID, Service Provider ID Qualifier, Prescription/ Service Reference Number, Date of Service, Fill Number, and Dispensing Status	Existing PDE has already been deleted.		Y	Y	Y	Y	Y	Y	Reject

663	Adj/Del	Adjustment/ Deletion Code, Contract Number, Plan Benefit Package ID, HIC number, Service Provider ID, Service Provider ID Qualifier, Prescription/ Service Reference Number, Date of Service, Fill Number, and Dispensing Status	Value of Dispensing Status on adjustment record and the record to be adjusted must be the same.		Y	Y	Y	Y	Y	Y	Reject
664	Adj/Del	Adjustment/ Deletion Code, Contract Number, Plan Benefit Package ID, HIC number, Service Provider ID, Service Provider ID Qualifier, Prescription/ Service Reference Number, Date of Service, Fill Number, Date Original Claim Received	For adjustment or deletion LI-NET PDEs submitted 1/1/2011 and forward, the Date Original Claim Received must equal the Date Original Claim Received submitted on the original.	Applies to LI NET only.	Y	Y	Y	Y	N	N	Reject
670	Cat Cov	GDCB, Catastrophic Coverage, True Out-of-Pocket Accumulator	For DOS prior to 1/1/2011, if Catastrophic Coverage Code = 'blank', GDCB must be greater than zero. For DOS 1/1/2011 and forward, if True Out-of-Pocket Accumulator < OOP Threshold, GDCB must be greater than zero.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
671	Cat Cov	GDCA, Catastrophic Coverage Code, True Out-of-Pocket Accumulator, Patient Pay Amount, Other TrOOP Amount, Reported Gap Discount, Low Income Cost Sharing Subsidy	For DOS prior to 1/1/2011, if Catastrophic Coverage Code = 'blank', GDCA must be zero. For DOS 1/1/2011 and forward, if (True Out-of-Pocket Accumulator + Patient Pay + Other TrOOP + Reported Gap Discount + LICS) <= OOP Threshold, GDCA must be zero.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
672	Cat Cov	GDCB, Catastrophic Coverage Code	For DOS prior to 1/1/2011, if Catastrophic Coverage Code is 'A', GDCB must be greater than zero.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject

673	Cat Cov	GDCA, Catastrophic Coverage Code	For DOS prior to 1/1/2011, if Catastrophic Coverage Code is 'C', GDCA must be greater than zero. For DOS 1/1/2011 and forward, if True Out-of-Pocket Accumulator = OOP Threshold, GDCA must be greater than zero.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
674	Cat Cov	GDCB, Catastrophic Coverage Code	For DOS prior to 1/1/2011, if Catastrophic Coverage Code is 'C', GDCB must be zero. For DOS 1/1/2011 and forward, if True Out-of-Pocket Accumulator = OOP Threshold, GDCB must be zero.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
675	Cat Cov	True Out-of-Pocket Accumulator, Patient Pay, Other TrOOP, Gap Discount , LICS	On PDE that straddles the Out-of-Pocket threshold where LICS is > than zero, CPP must be 95% of GDCA.	Effective for PDEs with a DOS => 1/1/2011. Applies to plans that apply the Defined Standard benefit in Catstrophic. Applies to catastrophic PDEs with co-insurance (for example, GDCA > $126 in 2011).	Y	Y	Y	Y	N	Y	Reject
690	Cost	Ingred Cost, Disp Fee, Sales Tax, Vaccine Administration Fee, Pt Pay, LICS, TrOOP, PLRO, CPP, NPP, Reported Gap Discount	For DOS prior to 1/1/2011, Sum of Cost Fields > Sum of Payment Fields +/- Rounding Error and Dispensing Status is 'blank' or 'P'. For DOS 1/1/2011 and forward, Sum of Cost Fields > Sum of Payment Fields +/- Rounding Error and Dispensing Status is 'blank'	System allows $.05 margin of error because some fields are calculated fields (i.e. CPP, NPP and LICS).	Y	Y	Y	Y	N	Y	Reject
691	Cost	GDCB, GDCA, Ingred Cost, Disp Fee, Sales Tax, Vaccine Administration Fee	The sum of GDCB and GDCA is not equal to the sum of Ingred Cost + Disp Fee + Sales Tax + Vaccine Administration Fee and Medicare is primary.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject

692	Cost	Ingred Cost, Disp Fee Paid, Sales Tax, Vaccine Administration Fee, Pt Pay, LICS, TrOOP, PLRO, CPP, NPP, Reported Gap Discount	Sum of Cost Fields < Sum of Payment Fields +/- Rounding Error and Dispensing Status is 'blank'.	For PDEs with DOS prior to 5/15/2010, the original edit logic applies: Sum of Cost Fields < Sum of Payment Fields +/- Rounding Error and Dispensing Status is 'blank' and CPP + NPP > 0. This edit version does not apply to MSP PDEs. For PDEs with DOS on or after 5/15/2010, CPP + NPP > 0 is no longer a condition for the edit. This edit version applies to all PDEs including MSP PDEs. The edit is bypassed when a non-Medicare primary payer paid more than the negotiated price.	Y	Y	Y	Y	N	Y	Reject
693	Cost	Ingred Cost, Disp Fee Paid, Sales Tax, Vaccine Administration Fee, Pt Pay, LICS, TrOOP, PLRO, CPP, NPP, Reported Gap Discount	Sum of Cost Fields < Sum of Payment Fields +/- Rounding Error and Dispensing Status is 'C'.		Y	Y	Y	Y	N	Y	Reject
694	Cost	Ingredient Cost, Dispensing Fee, Vaccine Administration Fee	The sum of Ingredient Cost, Dispensing Fee, and Vaccine Administration Fee must be > zero.	This requirement also applies to OTC drugs funded by adminstrative costs.	Y	Y	Y	Y	N	Y	Reject
695	Cost	Submitting Contract, Submitting PBP, NPP Amount	NPP Amount must be zero for LI NET PDEs.		Y	Y	Y	Y	N	N	Reject
696	Cost	True Out-of-Pocket Accumulator ,Total Gross Covered Drug Cost Accumulator	True Out-of-Pocket Accumulator cannot be greater than Total Gross Covered Drug Cost Accumulator.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Reject
700	Elig	HICN	The HICN does not match an existing Beneficiary.		Y	Y	Y	Y	Y	Y	Reject
701	Elig	Patient Date of Birth (DOB)	The DOB provided does not match the DOB on MBD.		Y	Y	Y	Y	Y	Y	Reject
702	Elig	Patient Gender	The Gender does not match the value on MBD.		Y	Y	Y	Y	Y	Y	Reject
703	Elig	Date of Service (DOS)	The DOS cannot be less than the DOB.		Y	Y	Y	Y	Y	Y	Reject
704	Elig	Date of Service (DOS)	The DOS cannot be greater than the date of death (DOD) + 32 days.		Y	Y	Y	Y	Y	Y	Reject

705	Elig	Date of Service (DOS)	The Beneficiary must be enrolled in Part D on the DOS.		Y	Y	Y	Y	Y	Y	Reject
706	Elig	Date of Service (DOS)	This DOS does not fall in a valid P2P period. The Beneficiary must be enrolled in this Contract on the DOS	This edit is bypassed for POS plans.	Y	Y	Y	Y	Y	Y	Reject
707	Elig	Date of Service (DOS) Contract Plan Benefit Package	The Beneficiary must be enrolled in this Part D Plan Benefit Package on the DOS.	If the contract on MBD matches the contract on the PDE, then the PBP on MBD must match the PBP on the PDE.	Y	Y	Y	Y	Y	Y	Reject
708	Elig	Date of Service (DOS) Contract Drug Coverage Status Code	Submitting Contract differs from contract of record; this PDE is subject to plan to plan reconciliation	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	Y	Y	Informational
709	Elig	Date of Service (DOS) Contract Drug Coverage Status Code	Even though the Submitting Sontract does not equal the contract of record, this PDE is not subject to plan-to-plan reconciliation. PDEs with drug coverage status of 'E' or 'O' are not eligible for plan-to-plan reconciliation.	Applies to non-covered drugs (enhanced and over-the-counter).	Y	Y	Y	Y	Y	Y	Informational
710	Elig	HICN	The beneficiary HICN has changed according to CMS records; use the corrected HICN for future submissions.	See the Corrected HICN field (positions 446-465) in the return file for the correct HICN.	Y	Y	Y	Y	Y	Y	Informational
711	Elig	Submitting Contract Contract of Record	PACE plans cannot submit plan-to-plan PDEs.		Y	Y	Y	Y	Y	Y	Reject
712	Elig	Date of Service (DOS), Submitting Contract	Submitting Contract was not prior Contract of Record for this P2P period.	Submitting plan should check their records to ensure the beneficiary was enrolled in that plan at some time during the benefit year.	Y	Y	Y	Y	Y	Y	Informational
713	Elig	Submitting Contract and PBP, Date of Service	The Submitting Contract/PBP does not offer Part D on Date of Service.	Compared to the HPMS extract data	Y	Y	Y	Y	Y	Y	Reject
714	Elig	Date of Service (DOS)	The DOS is greater than the date of death (DOD), but is within the 32 day allowable margin.		Y	Y	Y	Y	Y	Y	Informational

715	LICS	Low Income Cost-sharing Subsidy Amount (LICS)	Dollars reported in LICS are greater than zero. However, Beneficiary is not eligible for LICS subsidy.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. This edit is bypassed for 2006 dates of service.	Y	Y	Y	Y	N	Y	Reject
716	LICS	Patient Pay Amount, Other TrOOP Amount, PLRO	Pat Liab exceeds the statutorially defined maximum for Institutionalized Low Income beneficiary.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Institutionalized Low-Income beneficiaries have zero cost-sharing. This edit is bypassed for POS plans.	Y	Y	Y	Y	N	Y	Reject
717	LICS	Patient Pay Amount, Other TrOOP Amount, Catastrophic Coverage Code, TrOOP Accumulator, LICS Amount	Patient liability exceeds the statutorily defined pre-catastrophic maximum for Category 2 Low Income beneficiary.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Non-catastrophic cost-sharing maximum is determined by benefit year.	Y	Y	Y	Y	N	Y	Reject
718	LICS	Patient Pay Amount, Other TrOOP Amount, PLRO, Catastrophic Coverage Code, TrOOP Accumulator, LICS Amount	Patient liability exceeds the statutorily defined pre-catastrophic maximum for Category 1 Low Income beneficiary.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Non-catastrophic cost-sharing maximum is determined by benefit year.	Y	Y	Y	Y	N	Y	Reject
719	LICS	Patient Pay Amount, Other TrOOP Amount, PLRO,Catastrophic Coverage Code, TrOOP Accumulator, LICS Amount	Patient liability exceeds the statutorily defined pre-catastrophic maximum for Category 4 Low Income beneficiary who has met deductible.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Non-catastrophic cost-sharing maximum is determined by benefit year.	Y	Y	Y	Y	N	Y	Informational
720	LICS	Patient Pay Amount, Other TrOOP Amount, PLRO, Catastrophic Coverage Code, TrOOP Accumulator, LICS Amount	Patient Liability exceeds the statutorily defined catastrophic maximum for Category 1 or Category 2 Low Income beneficiary.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Applies to beneficiaries who have reached the out-of-pocket threshold.	Y	Y	Y	Y	N	Y	Reject
721	LICS	Patient Pay Amount, Other TrOOP Amount, PLRO, Catastrophic Coverage Code, TrOOP Accumulator	Patient liability exceeds the statutorily defined catastrophic maximum for Category 4 Low Income beneficiary who has reached the out-of-pocket threshold.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Catastrophic cost-sharing maximum is determined by benefit year.	Y	Y	Y	Y	N	Y	Reject

722	LICS	Low Income Cost-sharing Subsidy Amount (LICS), Drug Coverage Status Code, Date of Service	Dollars reported in LICS are greater than zero. However, beneficiary is not eligible for LICS subsidy in CMS systems. Plans must have documented evidence to substantiate LICS.	Applies to Dates of Service in 2006. Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	N	Y	Informational
735	NDC	Product/ Service ID	The NDC Code does not match a valid code on the NDC database.		Y	Y	Y	Y	Y	Y	Reject
736	NDC	Product/ Service ID	DOS < NDC effective date.	This edit code is disabled.	N	N	N	N	N	N	Reject
737	NDC	Drug Coverage Status Code, Product/Service ID	Inappropriate Drug coverage status code. Drug Coverage is not 'O' although the drug is on the OTC list.	This edit code is disabled.	N	N	N	N	N	N	Reject
738	NDC	Drug Coverage Status Code, Product/Service ID	The NDC identifies a Part D Non-coverable Drug.		Y	Y	Y	Y	Y	Y	Reject
739	NDC	Drug Coverage Status Code, Product/Service ID	This NDC is for a drug that is usually covered under Part B. If Plan determines that this drug is Part B covered, submit deletion record.	This edit code is disabled.	N	N	N	N	N	N	Informational
740	NDC	Product/Service ID	NDC is DESI drug.	This edit code is disabled.	N	N	N	N	N	N	Reject
741	NDC	Product/Service ID	The drug is always excluded from Part D; the drug is always covered by Part B.	This edit code is disabled.	N	N	N	N	N	N	Reject
742	NDC	Product/Service ID, Vaccine Administration Fee	If the amount in the Vaccine Administration Fee field is >0, then the NDC Code must qualify as a valid Part D vaccine.		Y	Y	Y	Y	Y	Y	Reject
743	NDC	Submitting Contract, Submitting PBP, Drug Coverage Status Code	Drug Coverage Status Code must be 'C' for LI NET PDEs.		Y	Y	Y	Y	N	N	Reject
744	NDC	Product Service ID	For DOS 1/1/2011 and forward, this drug is not a Part D Covered Drug because no MEDICARE COVERAGE GAP DISCOUNT PROGRAM AGREEMENT is on file for the manufacturer responsible for this labeler.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'.	Y	Y	Y	Y	Y	Y	Reject

755	Non Cov Drug	Drug Coverage Status Code, Catastrophic Coverage Code	If Drug Coverage Status Code equals 'E' or 'O', Catastrophic Coverage Code must not equal 'A' or 'C'.		Y	Y	Y	Y	N	Y	Reject
756	Non Cov Drug	Drug Coverage Status Code, CPP	If Drug Coverage Status Code is 'E' or 'O', then the Covered D Plan Paid Amount must be zero.		Y	Y	Y	Y	Y	Y	Reject
757	Non Cov Drug	Drug Coverage Status Code, Other TrOOP Amount	If Drug Coverage Status Code is 'E' or 'O', then Other TrOOP Amount must be zero.		Y	Y	Y	Y	N	Y	Reject
758	Non Cov Drug	Drug Coverage Status Code, LICS	If Drug Coverage Status Code is 'E' or 'O', then LICS must be zero.		Y	Y	Y	Y	N	Y	Reject
759	Non Cov Drug	Drug Coverage Status Code, GDCB	If Drug Coverage Status Code is 'E' or 'O', then GDCB must be zero.		Y	Y	Y	Y	N	Y	Reject
760	Non Cov Drug	Drug Coverage Status Code, GDCA	If Drug Coverage Status Code is 'E' or 'O', then GDCA must be zero		Y	Y	Y	Y	N	Y	Reject
761	Non Cov Drug	Drug Coverage Status Code, GDCA	If Drug Coverage Status Code is 'O' and Pricing Exception Code <> 'M', then Patient Pay Amount, LICS, Other TrOOP, PLRO, and CPP must each equal zero.	There cannot be a covered plan paid amount for OTC PDEs. Plans cannot charge beneficiaries for OTC drugs. Patient liability can be reported in as many as 4 fields: Patient Pay Amount, LICS, Other TrOOP Amount and/or PLRO.	Y	Y	Y	Y	N	Y	Reject
762	Non Cov Drug	Drug Coverage Status Code, Part D Benefit Type Code	If drug coverage status code is "E", the contract type must be Enhanced Alternative.		Y	Y	Y	Y	N	Y	Reject
763	Non Cov Drug	Drug Coverage Status Code, Vaccine Administration Fee	If Drug Coverage Status Code is 'E' or 'O', then the Vaccine Administration Fee must be zero.		Y	Y	Y	Y	Y	Y	Reject
764	Non Cov Drug	Drug Coverage Status Code, Total Gross Covered Drug Cost Accumulator	If Drug Coverage Status Code is 'E' or 'O', then the Total Gross Covered Drug Cost Accumulator must be blanks or zeros.		Y	Y	Y	Y	N	Y	Reject
765	Non Cov Drug	Drug Coverage Status Code, True Out-of-Pocket Accumulator	If Drug Coverage Status Code is 'E' or 'O', then the True Out-of-Pocket Accumulator must be blanks or zeros.		Y	Y	Y	Y	N	Y	Reject

766	Non Cov Drug	Drug Coverage Status Code, Beginning Benefit Phase	If Drug Coverage Status Code is 'E' or 'O', then the Beginning Benefit Phase must be blank.		Y	Y	Y	Y	N	Y	Reject
767	Non Cov Drug	Drug Coverage Status Code, Ending Benefit Phase	If Drug Coverage Status Code is 'E' or 'O', then the Ending Benefit Phase must be blank.		Y	Y	Y	Y	N	Y	Reject
768	Non Cov Drug	Drug Coverage Status Code, Reported Gap Discount	If Drug Coverage Status Code is 'E' or 'O', then the Reported Gap Discount must be blanks or zeros.		Y	Y	Y	Y	N	Y	Reject
769	Non Cov Drug	Drug Coverage Status Code, Gap Discount Plan Override Code	If Drug Coverage Status Code is 'E' or 'O', then the Gap Discount Plan Override Code must be blank.		Y	Y	Y	Y	N	Y	Reject
770	Non Cov Drug	Drug Coverage Status Code, Tier	If Drug Coverage Status Code is 'E' or 'O', then the Tier must be blank.		Y	Y	Y	Y	N	Y	Reject
771	Non Cov Drug	Drug Coverage Status Code, Formulary Code	If Drug Coverage Status Code is 'E' or 'O', then the Formulary Code must be blank.		Y	Y	Y	Y	N	Y	Reject
772	Non Cov Drug	Drug Coverage Status Code, Brand/Generic Code	If Drug Coverage Status Code is 'E' or 'O', then the Brand/Generic Code must be blank.		Y	Y	Y	Y	N	Y	Reject
775	Misc	Dispensing Status - record incompatibility	Incompatible Dispensing Status (blank cannot follow 'C' or 'P'). Record for a Partl ('P') or Compl ('C') fill is on file for this disp event. DDPS cannot accept another record with Disp Status = blank for the same dispensing event.	Applies to DOS prior to January 1, 2011.	Y	Y	Y	Y	Y	Y	Reject
776	Misc	Dispensing Status - record incompatibility	Incompatible Dispensing Status ('C' or 'P' cannot follow 'blank'). Record with unspecified fill status (blank) is on file for this same dispensing event. DDPS cannot accept another record with Partl ('P') or Compl ('C') fill for the same dispensing event.	Applies to DOS prior to January 1, 2011.	Y	Y	Y	Y	Y	Y	Reject

777	Misc	Service Provider, Prescription/Service Reference Number, Date of Service, Fill Number, Dispensing Status, Contract Number, PBP Number, Adjustment/Deletion Code	Duplicate PDE record. Duplicate PDE record exists in DDPS data warehouse.	Applies only if adjustment/deletion code is blank on the PDE record. Added match against the PDE file for duplicates and incompatible status. See edit 784 for associated edit.	Y	Y	Y	Y	Y	Y	Reject
778	Misc	Paid Date	Paid Date < DOS.	Applies only if paid date is present. Zeros or spaces are allowed.	Y	Y	Y	Y	Y	Y	Reject
779	Misc	Covered D Plan Paid Amount	Submitting Plan cannot report NPP for Covered Part D Drug.	The following Plan types are excluded: EA, Employer-only, Flexible Capitated Payment Demo, Fixed Capitated Payment Demo.	Y	Y	Y	Y	Y	Y	Reject
780	Misc	Service Provider ID Quaifier	Service Provider ID Qualifier must be '01' - NPI or '07' - NCPDP on standard claim.	Does not apply to X12, Paper, or Beneficiary Submitted claims.	Y	N	N	N	Y	Y	Reject
781	Misc	Service Provider ID	Service Provider ID is not on master provider file.	If Service Provider ID = "01", then validate as an NPI number. If Service Provider ID = "07", then validate as an NCPDP number.	Y	Y	Y	Y	Y	Y	Reject
782	Misc	N/A	Record had no error, but was submitted as part of a rejected batch. DDPS rejects batches with error rates exceeding 50%.	This edit has been disabled.	N	N	N	N	N	N	Reject
783	Misc	Service Provider ID	Service Provider was not an active pharmacy on DOS.	This edit has been disabled.	N	N	N	N	N	N	Reject
784	Misc	Service Provider, Prescription/Service Reference Number, Date of Service, Fill Number, Dispensing Status, Contract Number, PBP Number, Adjustment/Deletion Code	Duplicate PDE record, originally submitted by different contract.	Applies only if adjustment/deletion code is blank on the PDE record. Replaces Edit #777 when Contract Number differs from the original PDE that this record is duplicating. Original Submitting Contract is indicated in Return File.	Y	Y	Y	Y	Y	Y	Reject

785	Misc	Service Provider ID Qualifier, Service Provider ID, Prescription/Service Reference Number, Date of Service, Fill Number	Duplicate PDE record exists on this file. This PDE is not saved.	Applies only if a duplicate PDE is found on the same submitter file.	Y	Y	Y	Y	Y	Y	Reject
786	Misc	Beginning Benefit Phase, Ending Benefit Phase	Beginning and Ending Benefit Phase combination is invalid.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Effective for DOS 1/1/2011 and forward.	Y	Y	Y	Y	N	Y	Reject
787	Misc	Beginning Benefit Phase, Ending Benefit Phase, Total Gross Covered Drug Cost Accumulator , TrOOP Balance, GDCA, GDCB, Patient Pay Amount, Other TrOOP Amount, Reported Gap Discount, Low Income Cost Sharing Subsidy Amount	Beginning and Ending Benefit Phase combination does not match the True Out-of-Pocket Accumulator and/or Total Gross Covered Drug Cost Accumulator.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C'. Effective for DOS 1/1/2011 and forward.	Y	Y	Y	Y	N	Y	Informational
800	PACE	Catastrophic Coverage Code	The Catastrophic Coverage Code is invalid. Must be Blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
801	PACE	Patient Pay Amount	The Patient Pay Amount is invalid. Must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
802	PACE	Other TrOOP Amount	Other TrOOP Amount is invalid. Must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
803	PACE	Low Income Cost-sharing Subsidy Amount (LICS)	The LICS value is not a valid value. Must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
804	PACE	Patient Liability Reduction due to Other Payers (PLRO)	The PLRO must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
805	PACE	Non-covered Plan Paid Amount (NPP), Drug Coverage Status Code	When Drug Coverage Status Code = 'C' the Non-covered Plan Paid Amount must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject

806	PACE	Gross Drug Cost Below Out-Of-Pocket Threshold (GDCB)	GDCB is invalid; must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
807	PACE	Gross Drug Cost Above Out-Of-Pocket Threshold (GDCA)	GDCA is invalid; must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
808	PACE	Drug Coverage Status Code, Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax, Non-covered Plan Paid Amount	For a Covered Drug, Sum of Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax and Vaccine Administration Fee must equal Covered D Plan Paid Amount in PDE submitted by a PACE Program.		N	N	N	N	Y	N	Reject
809	PACE	Drug Coverage Status Code, Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax, Non-covered Plan Paid Amount	For a Non-Covered Drug, Sum of Ingredient Cost Paid, Dispensing Fee Paid, Total Amount Attributed to Sales Tax and Vaccine Administration Fee must equal Non-Covered Plan Paid Amount in PDE submitted by a PACE Program.		N	N	N	N	Y	N	Reject
810	PACE	Rebate Pass Through at POS	The Estimated Rebate at Point of Sale amount is invalid. Must equal zero in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
811	PACE	Total Gross Covered Drug Cost Accumulator	The Total Gross Covered Drug Cost Accumulator is missing or invalid. Must be equal to zeros or spaces in PDES submitted by PACE Programs.		N	N	N	N	Y	N	Reject
812	PACE	True Out-of-Pocket Accumulator	The True Out-of-Pocket Accumulator is invalid. Must be equal to zeros or spaces in PDES submitted by PACE Programs.		N	N	N	N	Y	N	Reject
813	PACE	Beginning Benefit Phase	The Beginning Benefit Phase is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject

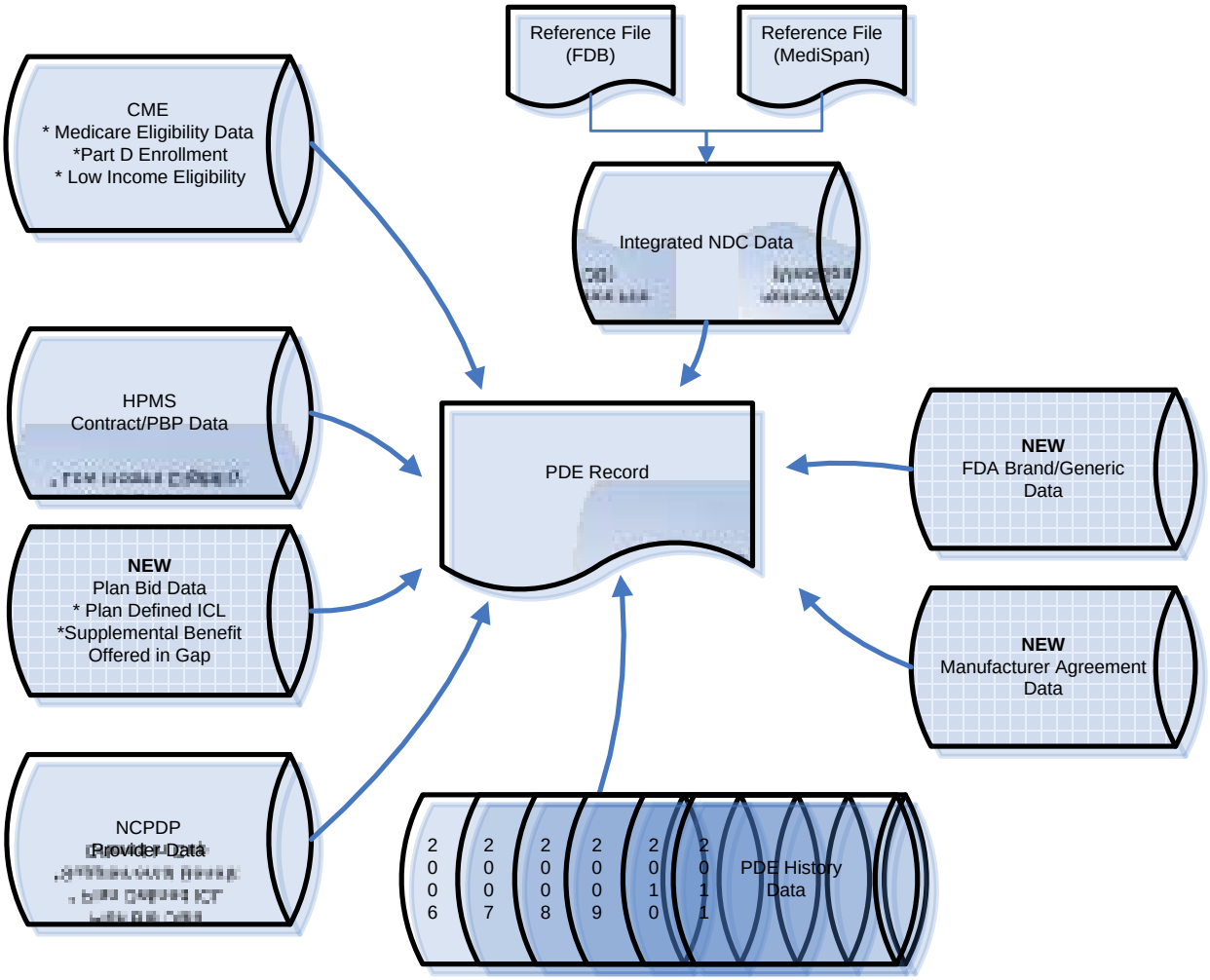
814	PACE	Ending Benefit Phase	The Ending Benefit Phase is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
815	PACE	Reported Gap Discount	The Reported Gap Discount is invalid. Must be equal to zeros or spaces in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
816	PACE	Tier	The Tier is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
817	PACE	Gap Discount Plan Override Code	The Gap Discount Plan Override Code is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
818	PACE	Formulary Code	The Formulary Code is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
819	PACE	Brand/Generic Code	The Brand/Generic Code is invalid. Must be equal to blank in PDEs submitted by PACE Programs.		N	N	N	N	Y	N	Reject
831	M/I	Formulary Code	The Formulary Code is missing or invalid. For DOS 1/1/2011 and forward, valid values are 'F' for Formulary or 'N' for Non-Formulary. For DOS prior to 2011, must be blank.	Applies to Covered Drugs only. Drug Coverage Status Code = 'C' . Required on PDEs with service dates effective January 1, 2011 forward. On PDEs with DOS prior to 1/1/2011, must be spaces.	Y	Y	Y	Y	N	Y	Reject
851	P2P Phase III Retro Enrollment	Submitting Contract/PBP, Original Contract/PBP, Updated Contract/PBP	The Contract of Record has been updated; a P2P condition now exists.	Identifies P2P Phase III condition # 1	Y	Y	Y	Y	Y	Y	Update
852	P2P Phase III Retro Enrollment	Submitting Contract/PBP, Original Contract/PBP, Updated Contract/PBP	Submitting Contract/PBP is now the Contract/PBP of Record; a P2P condition no longer exists.	Identifies P2P Phase III condition # 2	Y	Y	Y	Y	Y	Y	Update
853	P2P Phase III Retro Enrollment	Submitting Contract/PBP, Original Contract/PBP, Updated Contract/PBP	PBP of Record has been updated. This PDE continues to be a non-P2P PDE.	Identifies P2P Phase III condition # 3	Y	Y	Y	Y	Y	Y	Update

854	P2P Phase III Retro Enrollment	Submitting Contract/PBP, Original Contract/PBP, Updated Contract/PBP	The Contract of Record and PBP of Record have been updated. A new P2P condition is established.	Identifies P2P Phase III condition # 4	Y	Y	Y	Y	Y	Y	Update
855	P2P Phase III Retro Enrollment	Submitting Contract/PBP, Original Contract/PBP, Updated Contract/PBP	The Submitting Contract is now the Contract of Record but the Updated PBP of Record is different from the Submitting PBP. A P2P condition no longer exists.	Identifies P2P Phase III condition # 5	Y	Y	Y	Y	Y	Y	Update
865	Gap Discount	Reported Gap Discount, Low Income Cost-sharing Subsidy Amount (LICS)	Beneficiaries eligible for the low income cost sharing subsidy on the date of service are not eligible to receive a coverage gap discount.		Y	Y	Y	Y	N	Y	Reject
866	Gap Discount	Pricing Exception Code, Non- Standard Format Code, Reported Gap Discount.	MSP and COB claims are not eligible for the coverage gap discount.		Y	Y	Y	Y	N	Y	Reject
867	Gap Discount	NDC, Reported Gap Discount.	FDA does not designate this drug as NDA or BLA; therefore it is ineligible for the coverage gap discount.		Y	Y	Y	Y	N	Y	Reject
868	Gap Discount	Service Provider Qualifier Code, Reported Gap Discount.	Service Provider ID Qualifier cannot be '99' when PDE reports the coverage gap discount.		Y	Y	Y	Y	N	Y	Reject
869	Gap Discount	Beginning Benefit Phase ,Ending Benefit Phase, Total Gross Covered Drug Cost Accumulator, True Out-of-Pocket Accumulator	No portion of the claim is in the coverage gap, therefore the coverage gap discount does not apply.		Y	Y	Y	Y	N	Y	Reject

870	Gap Discount	Reported Gap Discount, Ingredient Cost Paid, Total Amount Attributed to Sales Tax, Dispensing Fee Paid, Vaccine Administration Fee , Total Gross Covered Drug Cost Accumulator,True Out-of-Pocket Accumulator, Non-Covered Plan Paid Amount (NPP), Gross Covered Drug Cost Below the Out-of-Pocket Threshold(GDCB), Gross Covered Drug Cost Above the Out-of-Pocket Threshold(GDCA), Patient Pay Amount, Low-Income Cost-Sharing Subsidy (LICS), Other TrOOP	Reported Gap Discount <> CMS Calculated Gap Discount +/- 0.05.		Y	Y	Y	Y	N	Y	Reject
871	Gap Discount	See Edit 870	Reported Gap Discount exceeds amount estimated by CMS.		Y	Y	Y	Y	N	Y	Reject
872	Gap Discount	See Edit 870	Reported Gap Discount is less than or equal to amount estimated by CMS. This PDE may be subject to additional scrutiny.		Y	Y	Y	Y	N	Y	Informational
873	Gap Discount	Reported Gap Discount, GDCB	For DOS 1/1/2011 forward, if Drug Coverage Status Code is 'C' and GDBC is zero, Reported Gap Discount must be zero.		Y	Y	Y	Y	N	Y	Reject
874	Gap Discount	Reported Gap Discount, Low Income Cost-sharing Subsidy Amount (LICS)	Reported Gap Discount is > zero. The sponsor provided LICS based on Best Available Evidence. Low income beneficiaries are not eligible to receive a Coverage Gap Discount.		Y	Y	Y	Y	N	Y	Reject

875	Gap Discount	Reported Gap Discount, Compound Code	Claims submitted with compound drugs are not eligible to receive the coverage gap discount.		Y	Y	Y	Y	N	Y	Reject
998	Misc	Contract/PBP of Record	Internal CMS issue regarding Contract/PBP of Record encountered	Compares data returned from MBD against the HPMS extract.	Y	Y	Y	Y	Y	Y	Reject
999	Misc	Various	Internal CMS system issue encountered	This is the system error edit code we will default to when we experience MBD issues where data is not returned for us to properly continue editing.	Y	Y	Y	Y	Y	Y	Reject

Appendix Two – DDPS Edit Tables



Appendix Three – Calculations

We use two approaches to edit Reported Gap Discount. Because this editing is resource intense, we limit it to PDEs that have passed all previous editing.

We use the first approach when we can clearly identify costs and supplemental benefits (if any) that fall in the Coverage Gap. In the first approach we use PDE data to compute Coverage Gap Cost and calculate Discount Eligible costs which exclude supplemental benefits (reported in NON-COVERED PLAN PAID AMOUNT - NPP), dispensing fee (reported in DISPENSING FEE PAID) and VACCINE ADMINISTRATION FEE(VAC). Because we use specific Accumulator values to identify costs in the Coverage Gap, there are four sets of calculations:

Set One: claim falls squarely in the Coverage Gap.

Set Two: claim with no supplemental benefits in the Coverage Gap that straddles either the Deductible or the Initial Coverage Period and the Coverage Gap

Set Three: claim with no supplemental benefits in the Coverage Gap that straddles the Coverage Gap and Catastrophic

Set Four: claim with no supplemental benefits in the Coverage Gap that straddles the Deductible and Catastrophic or the Initial Coverage Period and Catastrophic

In each set the first calculation determines where the claim falls in the benefit. The second calculation computes Discount Eligible Cost, accounting for cost in the Coverage Gap and supplemental benefits, if any. The third calculation, which is the generally the same in each set, computes Gap Discount.

We reserve the second approach for scenarios that are more complex, either because supplemental benefits reported in a straddle claim *may* fall in the Coverage Gap or because the Accumulator and Benefit Phase data are illogical. We expect a low volume of these PDEs and will scrutinize them further during Phase Two Data Quality Analysis.

When supplemental benefits (i.e. NPP > 0) reported on a straddle claim *may* fall in the Coverage Gap, we assume no supplemental benefit in the Coverage Gap and use the computed cost in the Coverage Gap as the basis for Discount Eligible Cost. We use plan bid information to identify plans that offer supplemental benefits in the Coverage Gap. Because EGWPs do not submit bids, we assume that the EGWP offers supplemental benefits in the Coverage Gap and include those PDEs in this approach when an EGWP straddle claim reports supplemental benefits (i.e. NPP > 0). See Sets Five, Six and Seven.

When the Accumulator and Benefit Phase data are illogical we assume that all pre-catastrophic costs (GROSS COVERED DRUG COST BELOW THE OUT-OF-POCKET THRESHOLD – GDCB) fall in the Coverage Gap and use GDCB as the basis for Discount Eligible Cost. See Set Eight.

Set One: Calculations for claims that fall squarely in the Coverage Gap

Calculation #1: Identify claim that falls squarely in the Coverage Gap

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC >= ICL and TrOOP ACC < OOP (Out of Pocket Threshold)
AND
TrOOP ACC + Δ TrOOP (Patient Pay + LICS + Other TrOOP + Reported Gap Discount) <= OOP
AND
TGCDC ACC + GDCB > ICL
AND GDCA = 0

Calculation #2: Compute Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee
If (NPP > = Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Drug Cost – NPP

Else If (NPP < (Dispensing Fee Paid + Vaccine Admin Fee)

or NPP = 0)) then

Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Calculated Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Set Two: Calculations for claims that straddle either the Deductible or the Initial Coverage Period and the Coverage Gap

Calculation #1: Identify claim that straddles either the Deductible or the Initial Coverage Period and the Coverage Gap

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC < ICL and TrOOP ACC < OOP (Out of Pocket Threshold)
AND
(TGCDC ACC + GDCB) > ICL
AND
TrOOP ACC + Δ TrOOP (Patient Pay + LICS + Other TrOOP + Reported Gap Discount) <= OOP
AND
GDCA = 0

Calculation #2: Compute Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee

Gap Drug Cost = TGCDC Acc + Drug Cost – ICL

If (Drug Cost – Gap Drug Cost) > =

(Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Gap Drug Cost

Else If ((Drug Cost – Gap Drug Cost)<

Dispensing Fee Paid + Vaccine Admin Fee then

Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Calculated Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Set Three: Calculations for claims that straddle the Coverage Gap and Catastrophic

Calculation #1: Identify claim that straddles the Coverage Gap and Catastrophic

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC >=ICL
AND
TrOOP ACC < OOP
And
TrOOP ACC + Δ TrOOP > OOP
AND
GDCA > 0

Calculation #2: Compute Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee

Gap Drug Cost = GDCB

If (Drug Cost – Gap Drug Cost > =

Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Gap Drug Cost

Else If (Drug Cost – Gap Drug Cost <

Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Calculated Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Set Four: Calculations for claims that straddles the Deductible and Catastrophic or the Initial Coverage Period and Catastrophic

Calculation #1: Identify claims that straddle the Deductible and Catastrophic or the Initial Coverage Period and Catastrophic

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC < ICL
AND
TrOOP ACC < OOP
AND
TrOOP ACC + Δ TrOOP > OOP
AND
GDCA> 0

Calculation #2: Compute Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid+ Vaccine Admin Fee

Gap Drug Cost = TGCDC ACC + GDCB - ICL

If (Drug Cost – Gap Drug Cost > =

(Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Gap Drug Cost

Else If (Drug Cost – Gap Drug Cost <

Dispensing Fee Paid + Vaccine Admin Fee) then

Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Calculated Gap Discount

Calculated Gap Discount = Discount Eligible Cost * 0.5

Set Five: Calculations for straddle claims that may have supplemental benefits in the Coverage Gap; claim straddles either the Deductible or the Initial Coverage Period and the Coverage Gap

Calculation #1: Identifies claims that straddle either the Deductible or the Initial Coverage Period and the Coverage Gap

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC < ICL and TrOOP ACC < OOP
AND
TGCDC ACC + GDCB > ICL
AND
TrOOP ACC + Δ TrOOP < OOP
AND
GDCA = 0

Note: NPP <> 0 and either Bid indicates that plan offers supplemental benefits in the Coverage Gap or plan is an EGWP

Calculation #2: Compute Maximum Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee

Gap Drug Cost = TGCDC ACC + Drug Cost - ICL

If (Drug Cost – Gap Drug Cost > =

Dispensing Fee Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Gap Drug Cost

Else If (Drug Cost – Gap Drug Cost <

Dispensing Fee Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Maximum Gap Discount

Max Gap Discount = Max Discount Eligible Cost * 0 .5

Step Six: Calculations for straddle claims that may have supplemental benefits in the Coverage Gap; claim straddles Coverage Gap and Catastrophic

Calculation #1: Identifies claim that straddles Coverage Gap and Catastrophic

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC >=ICL and TrOOP ACC < OOP
AND
TrOOP ACC + Δ TrOOP > OOP
AND
GDCA > 0

Note: NPP <> 0 and either Bid indicates that plan offers supplemental benefits in the Coverage Gap or plan is an EGWP

Calculation #2: Compute Maximum Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee

Gap Drug Cost = GDCB

If (Drug Cost – Gap Drug Cost > =

Dispensing Fee Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Gap Drug Cost

Else If (Drug Cost – Gap Drug Cost <

Dispensing Fee Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Ingredient Cost + Sales

Calculation #3: Compute Maximum Gap Discount

Max Gap Discount = Max Discount Eligible Cost * 0.5

Set Seven: Calculations for straddle claims that may have supplemental benefits in the Coverage Gap; claim straddles either Deductible and Catastrophic or Initial Coverage Period and Catastrophic

Calculation #1: Identifies claims that straddle either Deductible and Catastrophic or Initial Coverage Period and Catastrophic

TGCDC ACC and TrOOP ACC match the Benefit Phases
AND
TGCDC ACC < ICL and TrOOP ACC < OOP
AND
TrOOP ACC + Δ TrOOP > OOP
AND
GDCA> 0

Note: NPP <> 0 and either Bid indicates that plan offers supplemental benefits in the Coverage Gap or plan is an EGWP

Calculation #2: Compute Maximum Discount Eligible Cost

Drug Cost = Ingredient Cost + Sales Tax + Dispensing Fee Paid + Vaccine Admin Fee

Gap Drug Cost = TGCDC Acc + GDCB - ICL

If (Drug Cost – Gap Drug Cost > =

Dispensing Fee Paid Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Gap Drug Cost

Else If (Drug Cost – Gap Drug Cost <

Dispensing Fee Paid + Vaccine Admin Fee) then

Max Discount Eligible Cost= Ingredient Cost + Sales Tax

Calculation #3: Compute Maximum Gap Discount

Max Gap Discount = Max Discount Eligible Cost * 0.5

Set Eight: PDEs with illogical Accumulator and Benefit Phase data are illogical

Calculation #1: Compute Maximum Discount Eligible Cost

If GDCB >= (Ingredient Cost + Sales Tax) then
Max Discount Eligible Cost = Ingredient Cost + Sales Tax

Else If GDCB < (Ingredient Cost + Sales Tax) then
Max Discount Eligible Cost = GDCB

Calculation #2: Compute Maximum Gap Discount

Max Gap Discount = Max Discount Eligible Cost * 0.5

APPENDIX FOUR - GAP DISCOUNT CALCULATION PROCESS