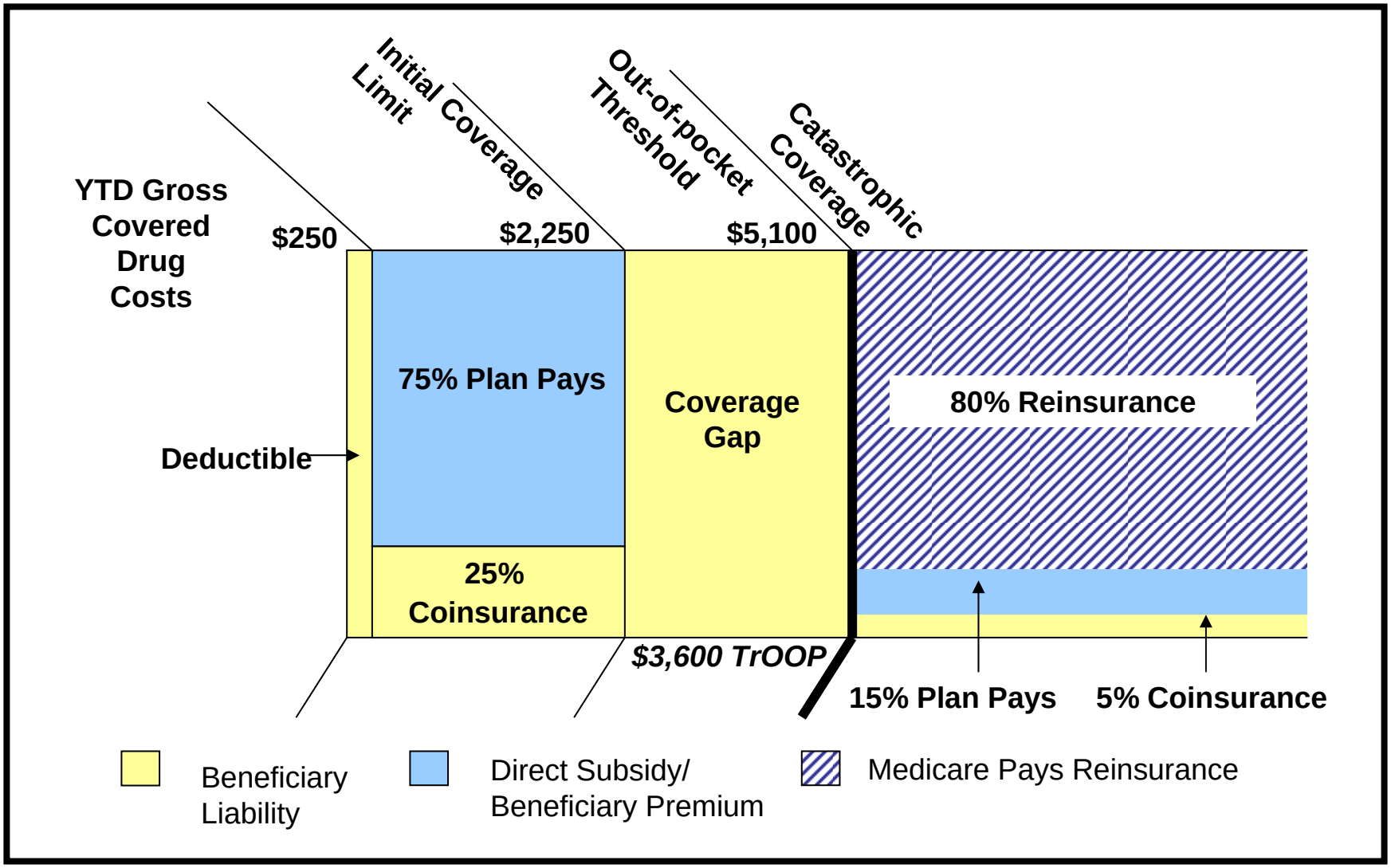
LTC
LEADING THROUGH CHANGE

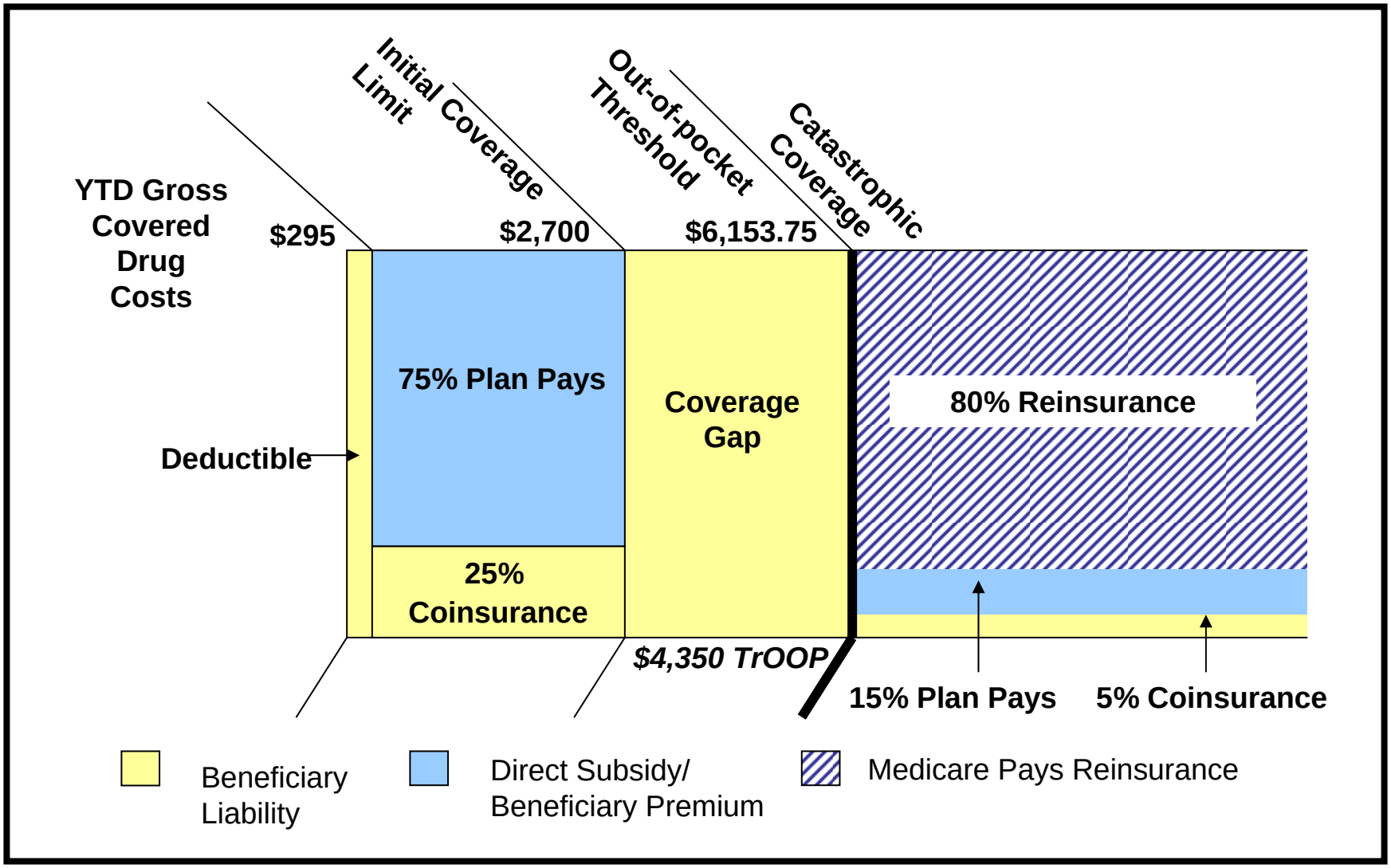
2008 Regional Technical Assistance
PRESCRIPTION DRUG EVENT DATA

CMS Centers for Medicare & Medicaid Services

2006 Defined Standard Benefit



2009 Defined Standard Benefit



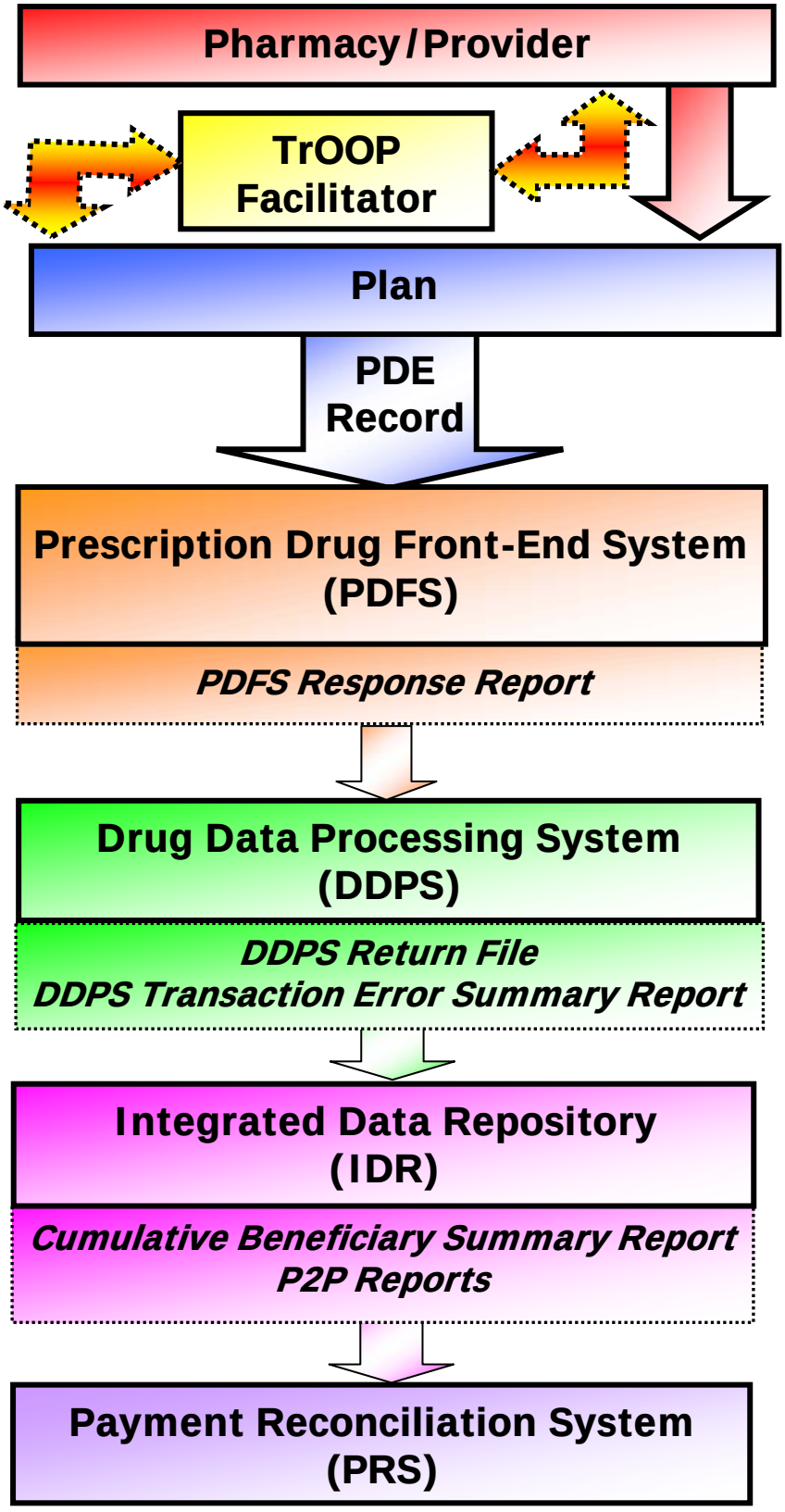
PDE DATA SUBMISSION TIMELINE

NEW CONTRACT EFFECTIVE JANUARY 1, 2009

CY	Data Submission Type	Submission Timeline
2009	EDI Agreement and Submitter Application Deadline	October 31, 2008
2009	Certification Complete*	January 31, 2009
2009	First Production File Due	March 31, 2009
2009	Production Submissions	Ongoing Monthly Submissions March 31, 2009 – May 31, 2010
2009	Final Submission Deadline	May 31, 2010
2009	Direct & Indirect Remuneration (DIR) Submission Deadline	June 30, 2010

* Only new contracts submitting directly or new third party submitters submitting in CY2009 must complete the testing and certification process.

PDE Process Dataflow



PDE Record File Structure Summary

RT HDR – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BHD.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test/Certification Indicator
- Filler

RT BHD – BATCH HEADER (Plan Info)
Must follow RT HDR or RT BTR and must be followed by RT DET.

- Record ID
- Sequence Number
- Contract Number
- PBP ID
- Filler

RT DET – DETAIL RECORD (Drug Event Information)
Must follow RT BHD or RT DET and may be followed by another RT DET or RT BTR. The detail record contains 40 data elements that must be populated with data in order to provide CMS with the information required for identifying each unique prescription drug event and calculating payment.

RT BTR – BATCH TRAILER
Must follow RT DET and may be followed by a RT BHD or RT TLR.

- Record ID
- Sequence Number
- Contract No
- PBP ID
- DET Record Total
- DET Accepted Record Total
- DET Informational Record Total
- DET Rejected Record Total
- Filler

RT TLR – FILE TRAILER
Must follow RT BTR, and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- TLR BHD Record Total
- TLR DET Record Total
- TLR DET Accepted Record Total
- TLR DET Informational record total
- TLR DET Rejected Record Total
- Filler

DETAIL LEVEL

BATCH LEVEL

FILE LEVEL

PDE Record Layout

HDR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'HDR'
2	SUBMITTER-ID	4 – 9	X(6)	'SXXXXX'
3	FILE-ID	10 – 19	X(10)	
4	TRANSACTION-DATE	20 – 27	9(8)	CCYYMMDD
5	PROD-TEST-CERT-IND	28 – 31	X(4)	'PROD' 'CERT' OR 'TEST'
6	FILLER	32 - 512	X(481)	SPACES

BHD RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BHD'
2	SEQ-NO	4 – 10	9(7)	MUST BEGIN WITH 0000001
3	CONTRACT NO	11 – 15	X(5)	ASSIGNED BY CMS
4	PBP ID	16 – 18	X(3)	ASSIGNED BY CMS
5	FILLER	19 – 512	X(494)	SPACES

DET RECORD

DET RECORDS FOLLOW BHD RECORDS AND ARE FOLLOWED BY ADDITIONAL DET RECORDS OR BTR RECORDS.

BTR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'BTR'
2	SEQ-NO	4 – 10	9(7)	MUST BEGIN WITH 0000001
3	CONTRACT NO	11 – 15	X(5)	MUST MATCH BHD
4	PBP ID	16 – 18	X(3)	MUST MATCH BHD
5	DET RECORD TOTAL	19 – 25	9(7)	TOTAL COUNT OF DET RECORDS
6	DET ACCEPTED RECORD TOTAL*	26 – 32	9(7)	SPACES
7	DET INFORMATIONAL RECORD TOTAL*	33 – 39	9(7)	SPACES
8	DET REJECTED RECORD TOTAL*	40 – 46	9(7)	SPACES
9	FILLER	47 – 512	X(466)	SPACES

TLR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'TLR'
2	SUBMITTER-ID	4 – 9	X(6)	MUST MATCH HDR
3	FILE-ID	10 – 19	X(10)	MUST MATCH HDR
4	TLR BHD RECORD TOTAL	20 – 28	9(9)	TOTAL COUNT OF BHD RECORDS
5	TLR DET RECORD TOTAL	29 – 37	9(9)	TOTAL COUNT OF DET RECORDS
6	TLR DET ACCEPTED RECORD TOTAL*	38 – 46	9(9)	SPACES
7	TLR DET INFORMATIONAL RECORD TOTAL*	47 – 55	9(9)	SPACES
8	TLR DET REJECTED RECORD TOTAL*	56 – 64	9(9)	SPACES
9	FILLER	65 – 512	X(448)	SPACES

***These fields will be populated as necessary during data processing.**

DET RECORD

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
1	RECORD-ID		1 – 3	X(3)	'DET'
2	SEQUENCE NO		4 – 10	9(7)	MUST BEGIN WITH 0000001
3	CLAIM CONTROL NO		11 – 50	X(40)	OPTIONAL
4	HICN		51 – 70	X(20)	HICN OR RRB#
5	CARDHOLDER ID	302-C2	71 – 90	X(20)	PLAN IDENTIFICATION OF BENEFICIARY
6	PATIENT DOB	304-C4	91 – 98	9(8)	CCYYMMDD/OPTIONAL
7	PATIENT GENDER	305-C5	99 – 99	9(1)	1=MALE 2=FEMALE
8	DATE OF SERVICE	401-D1	100 – 107	9(8)	CCYYMMDD
9	PAID DATE		108 – 115	9(8)	CCYYMMDD/FALLBACK ONLY
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 – 124	9(9)	00NNNNNNN
11	FILLER		125 – 126	X(2)	SPACES
12	PRODUCT SERVICE ID	407-D7 or 489-TE	127 – 145	X(19)	'MMMMMDDDDPP'
13	SERVICE PROVIDER ID QUALIFIER	202-B2	146 – 147	X(2)	STANDARD '01'=NPI '07'=NCPDP # NON-STANDARD '01'=NPI '06'=UPIN '07'=NCPDP # '08'=STATE LICENSE '11'=FEDERAL TAX ID '99'=OTHER
14	SERVICE PROVIDER ID	201-B1	148 – 162	X(15)	
15	FILL NO	403-D3	163 – 164	9(2)	0=NOT AVAILIABLE 1-99=NUMBER OF FILLS
16	DISPENSING STATUS	343-HD	165 – 165	X(1)	<BLANK>=NOT SPECIFIED 'P'=PARTIAL FILL 'C'=COMPLETION OF PARTIAL FILL
17	COMPOUND CODE	406-D6	166 – 166	9(1)	0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND (MULTIPLE)
18	DISPENSE AS WRITTEN (DAW)	408-D8	167 – 167	X(1)	'0'=NO PRODUCT SELECTION INDICATED '1'=SUB NOT ALLOWED BY PRESCRIBER '2'=SUB ALLOWED; PATIENT REQUESTED PRODUCT DISPENSED '3'=SUB ALLOWED – PHARMACIST SELECTED PRODUCT DISPENSED '4'=SUB ALLOWED – GENERIC DRUG NOT IN STOCK '5'=SUB ALLOWED – BRAND DRUG DISPENSED AS GENERIC '6'=OVERRIDE '7'=SUB NOT ALLOWED – BRAND DRUG MANDATED BY LAW '8'=SUB ALLOWED GENERIC DRUG NOT AVAILABLE IN MARKETPLACE '9'=OTHER
19	QUANTITY DISPENSED	442-E7	168 – 177	9(7)V999	# OF UNITS, GRAMS, MILILITER, OTHER.
20	DAYS SUPPLY	405-D5	178 – 180	9(3)	0-999
21	PRESCRIBER ID QUALIFIER	466-EZ	181 – 182	X(2)	'01'=NPI '06'=UPIN '08'=STATE LICENCE NO '12'=DEA #
22	PRESCRIBER ID NO	411-DB	183 – 197	X(15)	
23	DRUG COVERAGE STATUS CODE		198 – 198	X(1)	'C'=COVERED 'E'=ENHANCED 'O'=OTC DRUGS

DET RECORD (continued)

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	VALUE
24	ADJUSTMENT/DELETION CODE		199 – 199	X(1)	'A'=ADJUSTMENT 'D'=DELETION <BLANK>=ORIGINAL PDE RECORD
25	NON-STANDARD FORMAT CODE		200 – 200	X(1)	'X'=X12 837 'B'=BENEFICIARY SUBMITTED CLAIM 'P'=PAPER CLAIM FROM PROVIDER 'C'=COB CLAIM <BLANK>=NCPDP FORMAT
26	PRICING EXCEPTION CODE		201 – 201	X(1)	'M'=MEDICARE AS SECONDARY PAYER (MSP) IN NETWORK OR OUT-OF-NETWORK 'O'=OUT-OF-NETWORK PHARMACY (NON-MSP) <BLANK>=IN NETWORK PHARMACY AND MEDICARE PRIMARY
27	CATASTROPHIC COVERAGE CODE		202 – 202	X(1)	'A'=ATTACHMENT POINT MET ON THIS EVENT 'C'=ABOVE ATTACHMENT POINT <BLANK>=ATTACHMENT POINT NOT MET
28	INGREDIENT COST PAID	506-F6	203 – 210	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
29	DISPENSING FEE PAID	507-F7	211 – 218	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
30	AMOUNT ATTRIBUTED TO SALES TAX		219 – 226	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
31	GDCB		227 – 234	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
32	GDCA		235 – 242	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
33	PATIENT PAY AMOUNT	505-F5	243 – 250	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
34	OTHER TrOOP AMOUNT		251 – 258	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
35	LICS AMOUNT		259 – 266	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
36	PLRO		267 – 274	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
37	CPP		275 – 282	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
38	NPP		283 – 290	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
39	ESTIMATED REBATE AT POS		291 – 298	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
40	VACCINE ADMINISTRATION FEE		299 – 306	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
41	PRESCRIPTION ORIGIN CODE	419-DJ	307 – 307	X(1)	'0'=NOT SPECIFIED '1'=WRITTEN '2'=TELEPHONE '3'=ELECTRONIC '4'=FACSIMILE <BLANK>
42	FILLER		308 – 415	X(108)	SPACES
43	PBP OF RECORD*		416 – 418	X(3)	SPACES
44	ALTERNATE SERVICE PROVIDER ID QUALIFIER*		419 – 420	X(2)	SPACES
45	ALTERNATE SERVICE PROVIDER ID*		421 – 435	X(15)	SPACES
46	ORIGINAL SUBMITTING CONTRACT*		436 – 440	X(5)	SPACES
47	P2P CONTRACT OF RECORD*		441 – 445	X(5)	SPACES
48	CORRECTED HICN*		446 – 465	X(20)	SPACES
49	ERROR COUNT*		466 – 467	9(2)	SPACES
50-59	ERROR CODE FIELDS*		468 – 497	X(3)	SPACES
60	EXCLUSION REASON CODE		498 – 500	X(3)	SUBCATEGORY REJECT CODE FOR AN NDC ERROR CODE OF 738 IDENTIFIED IN FIELDS 50-59
61	FILLER		501 – 512	X(12)	SPACES

***These fields will be populated as necessary during data processing.**

DEFINED STANDARD BENEFIT

	PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
2006	Deductible	≤$250	100%
	Initial Coverage Period	>$250 and ≤ $2,250	25%
	Coverage Gap	>$2,250 and ≤ $5,100	100%
	Catastrophic Coverage	>$5,100	Greater of 5% coinsurance or $2/$5 (generic/ brand) co-payment
	TrOOP = $3,600		
2008	Deductible	≤$275	100%
	Initial Coverage Period	>$275 and ≤ $2,510	25%
	Coverage Gap	>$2,510 and ≤ $5,726.25	100%
	Catastrophic Coverage	>$5,726.25	Greater of 5% coinsurance or $2.25/$5.60 (generic/ brand) co-payment
	TrOOP = $4,050		
2009	Deductible	≤$295	100%
	Initial Coverage Period	>$295 and ≤ $2,700	25%
	Coverage Gap	>$2,700 and ≤ $6,153.75	100%
	Catastrophic Coverage	>$6,153.75	Greater of 5% coinsurance or $2.40/$6.00 (generic/ brand) co-payment
	TrOOP = $4,350		

LICS CATEGORIES AND COST-SHARING

			Maximum LI Beneficiary Cost-Sharing		
	Co-pay Category	Co-Pay Category Eligibility Criteria	Annual Deductible? If Yes, amount	Pre-Catastrophic Coverage Phase	Catastrophic Coverage Phase
2006	2	Deemed FBDE* with income ≤ 100% FPL**	No	$1-generic $3-brand	$0
	1	Deemed SSI*** recipient, MSP# participant, or FBDE* with income >100% FPL or LIS applicant with income <135% FPL** and resources not more than $7,500 ($12,000 if married)##	No	$2-generic $5-brand	$0
	4	LIS applicant with income <150% FPL** with resources between $7,500-$11,500 ($12,000-$23,000 if married)##	Yes&/$50	15%	$2-generic $5-brand
	3	Deemed an institutionalized FBDE*	No	$0	$0
2008	2	Deemed FBDE* with income ≤ 100% FPL**	No	$1.05-generic $3.10-brand	$0
	1	Deemed SSI*** recipient, MSP# participant, or FBDE* with income >100% FPL or LIS applicant with income <135% FPL** and resources not more than $7,790 ($12,440 if married)##	No	$2.25-generic $5.60-brand	$0
	4	LIS applicant with income <150% FPL** with resources between $7,790-$11,990 ($12,440-$23,970 if married)##	Yes&/$56	15%	$2.25-generic $5.60-brand
	3	Deemed an institutionalized FBDE*	No	$0	$0
2009	2	Deemed FBDE* with income ≤ 100% FPL**	No	$1.10-generic $3.20-brand	$0
	1	Deemed SSI*** recipient, MSP# participant, or FBDE* with income >100% FPL or LIS applicant with income <135% FPL** (2009 resources available around September 2008)	No	$2.40-generic $6.00-brand	$0
	4	LIS applicant with income <150% FPL** (2009 resources available around September 2008)	Yes&/$60	15%	$2.40-generic $6.00-brand
	3	Deemed an institutionalized FBDE*	No	$0	$0

*FBDE = Full Benefit Dual-Eligible

**FPL = Federal Poverty Level

***SSI = Supplemental Security Income

#MSP = Medicare Savings Program participant [Qualified Medicare Beneficiary-only (QMB)/Specified Low Income Medicare Beneficiary-only (SLMB)/Qualified Individual (QI)]

##Resource amounts include $1,500 per person for burial expenses for co-pay categories 1 and 4.

&Subject to plan benefit design; LIS deductible cannot exceed plan deductible.

August 2008

MAPPING TO THE DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS

	Rule #	YTD GROSS COVERED DRUG COST	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
2006	1	≤ $250	0%
	2	> $250 and ≤ $2,250	75%
	3	> $2,250 and ≤ $5,100	0%
	4	> $5,100 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2/$5)
2008	1	≤ $275	0%
	2	> $275 and ≤ $2,510	75%
	3	> $2,510 and ≤ $5,726.25	0%
	4	> $5,726.25 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)
2009	1	≤ $295	0%
	2	> $295 and ≤ $2,700	75%
	3	> $2,700 and ≤ $6,153.75	0%
	4	> $6,153.75 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)

MAPPING TO THE DEFINED STANDARD BENEFIT TO CALCULATE CPP FOR FLEXIBLE AND FIXED CAPITATED OPTIONS

	Rule #	YTD GROSS COVERED DRUG COST	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT	
			FLEXIBLE CAPITATED OPTION	FIXED CAPTITATED OPTION
2006	1	≤ $250	0%	
	2	> $250 and ≤ $2,250	75%	
	3	> $2,250 and ≤ $5,100	0%	
	4	> $5,100 and ≤ OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2/$5)	N/A
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2/$5)	
2008	1	≤ $275	0%	
	2	> $275 and ≤ $2,510	75%	
	3	> $2,510 and ≤ $5,726.25	0%	
	4	> $5,726.25 and ≤ OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)	N/A
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.25/$5.60)	
2009	1	≤ $295	0%	
	2	> $295 and ≤ $2,700	75%	
	3	> $2,700 and ≤ $6,153.75	0%	
	4	> $6,153.75 and ≤ OOP threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)	N/A
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.40/$6.00)	

PDFS Edit Codes

EDIT CODE LOGIC AND RANGES

SERIES	RANGES	EXPLANATION
100	**126-150**	File-level errors on the HDR.
	176-199	File-level errors on the TLR records.
200	**226-250**	Batch-level errors on the BHD.
	276-299	Batch-level errors on the BTR records.
600	**601-602**	Detail-level errors on DET records.

FILE-LEVEL EDIT CODES

EDIT CODE	EDIT DESCRIPTION	
126	RECORD ID IS MISSING OR INVALID.	HDR
127	HDR RECORD IS OUT OF SEQUENCE. HDR RECORD IS NOT FIRST RECORD IN FILE OR DOES NOT FOLLOW A TLR RECORD.	
128	SUBMITTER ID IS MISSING.	
129	SUBMITTER ID IS NOT ON FILE.	
130	SUBMITTER ID IS NOT CERTIFIED TO SEND PRODUCTION DATA.	
131	FILE ID IS MISSING. FILE ID IS BLANK.	
132	FILE ID IS A DUPLICATE. FILE ID IS A DUPLICATE OF ANOTHER FILE THAT WAS ACCEPTED WITHIN THE LAST 12 MONTHS.	
133	TRANS-DATE IS MISSING OR INVALID. MUST BE A VALID DATE IN CCYYMMDD FORMAT AND CANNOT BE A FUTURE DATE.	
134	PROD-TEST-CERT-IND IS MISSING OR INVALID. PROD-TEST-CERT-IND IS BLANK OR NOT EQUAL TO 'PROD', 'TEST', OR 'CERT'.	
176	TLR RECORD IS OUT OF SEQUENCE. TLR RECORD DOES NOT FOLLOW A BTR RECORD.	TLR
177	SUBMITTER ID IS MISSING.	
178	SUBMITTER ID IS NOT EQUAL TO THE SUBMITTER ID IN THE HDR RECORD.	
179	FILE ID IS MISSING.	
180	FILE ID IS NOT EQUAL TO THE FILE ID IN THE HDR RECORD.	
181	TLR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF BATCHES IN THE FILE.	
182	DET RECORD TOTAL ON THE TLR RECORD IS MISSING OR DOES NOT MATCH THE COMPUTED NUMBER OF DET RECORDS IN THE FILE.	
183	TEST/CERT FILE CANNOT EXCEED 5,000 RECORDS.	
184	PROD FILE CANNOT EXCEED 3,000,000 RECORDS (EFFECTIVE AUGUST 2006).	

PDFS Edit Codes

BATCH-LEVEL EDIT CODES

EDIT CODE	EDIT DESCRIPTION	
226	BHD RECORD IS OUT OF SEQUENCE. BHD RECORD DOES NOT FOLLOW EITHER A HDR OR BTR RECORD.	BHD
227	SEQUENCE NUMBER IS MISSNG OR INVALID. SEQUENCE NUMBER CANNOT BE BLANK OR ZERO. SEQUENCE NUMBER MUST START WITH A 0000001.	
228	SEQUENCE NUMBER IS INVALID. SEQUENCE NUMBER IS OUT OF ORDER.	
229	CONTRACT NUMBER IS MISSING.	
230	CONTRACT NUMBER DOES NOT MATCH NUMBER ASSIGNED BY CMS.	
231	CONTRACT NUMBER IS NOT ACTIVE.	
232	SUBMITTER NOT AUTHORIZED TO SUBMIT FOR THIS CONTRACT.	
233	PBP ID IS MISSING.	
234	PBP IS NOT VALID FOR THE CONTRACT ID.	
235	PBP ID IS NOT ACTIVE. NOT AUTHORIZED TO SUBMIT PRODUCTION DATA.	
236	TEST CONTRACT NUMBER NOT AUTHORIZED FOR PRODUCTION DATA.	
237	TEST/CERT FILES MUST USE TEST CONTRACT NUMBER AND PBP ID.	
276	BTR RECORD IS OUT OF SEQUENCE. BTR RECORD DOES NOT FOLLOW A DET RECORD.	BTR
277	SEQUENCE NUMBER IS MISSING OR INVALID. SEQUENCE NUMBER IS NOT NUMERIC.	
278	SEQUENCE NUMBER IS NOT EQUAL TO THE BHD SEQUENCE NUMBER.	
279	CONTRACT NUMBER IS MISSING OR INVALID.	
280	CONTRACT NUMBER DOES NOT MATCH THE CONTRACT NUMBER IN THE BHD RECORD.	
281	PBP ID IS MISSING.	
282	PBP ID DOES NOT MATCH THE PBP ID IN THE BHD RECORD.	
283	DET RECORD TOTAL ON THE BTR RECORD IS MISSING.	
284	BTR RECORD TOTAL DOES NOT MATCH THE TOTAL NUMBER OF DETAIL RECORDS.	

DETAIL-LEVEL EDIT CODES

EDIT CODE	RECORD ID	EDIT DESCRIPTION	
601	DET	DET RECORD IS OUT OF SEQUENCE. DET RECORD DOES NOT FOLLOW A BHD OR ANOTHER DET RECORD.	DET
602	DET	SEQUENCE NUMBER IS INVALID. DET SEQUENCE NUMBER IS NOT NUMERIC OR NOT EQUAL TO THE COMPUTED SEQUENCE NUMBER.	

DDPS Edit Codes

NATIONAL DRUG CODE (NDC)

EDIT CODE	EDIT DESCRIPTION
735	NDC CODE IS INVALID. NDC CODE DOES NOT MATCH A VALID CODE ON THE NDC DATABASE.
737	INAPPROPRIATE DRUG COVERAGE STATUS CODE. DRUG COVERAGE IS NOT 'O' ALTHOUGH THE DRUG IS ON THE OTC LIST.
738	INAPPROPRIATE DRUG COVERAGE. DRUG COVERAGE IS 'C' ALTHOUGH THE DRUG IS ON THE EXCLUSION LIST.
739	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. [INFORMATIONAL]
740	NDC IS DESI DRUG.
741	THE DRUG IS ALWAYS EXCLUDED FROM PART D; THE DRUG IS ALWAYS COVERED BY PART B.
742	IF THE AMOUNT OF THE VACCINE ADMINISTRATION FEE FIELD IS >ZERO, THEN THE NDC CODE MUST QUALIFY AS A VALID PART D VACCINE DRUG.

DRUG COVERAGE STATUS CODE

EDIT CODE	EDIT DESCRIPTION
755	IF DRUG COVERAGE STATUS CODE EQUALS 'E' OR 'O', CATASTROPHIC COVERAGE CODE MUST NOT EQUAL 'A' OR 'C'.
756	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE COVERED D PLAN PAID AMOUNT MUST BE ZERO.
757	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN OTHER TrOOP AMOUNT MUST BE ZERO.
758	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN LICS MUST BE ZERO.
759	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN GDCB MUST BE ZERO.
760	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN GDCA MUST BE ZERO.
761	IF DRUG COVERAGE IS 'O', THEN PATIENT PAY AMOUNT, LICS, OTHER TrOOP, AND PLRO MUST EQUAL ZERO.
762	IF DRUG COVERAGE STATUS CODE IS 'E', THE CONTRACT TYPE MUST BE ENHANCED ALTERNATIVE. (EFFECTIVE NOVEMBER 2006)
763	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O' THEN THE VACCINE ADMINISTRATION FEE MUST BE ZERO.

MISCELLANEOUS

EDIT CODE	EDIT DESCRIPTION
775	INCOMPATIBLE DISPENSING STATUS ('BLANK' CANNOT FOLLOW 'C' OR 'P'). RECORD FOR A PARTIAL OR COMPLETE FILL IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH DISPENSING STATUS = BLANK FOR THE SAME DISPENSING EVENT.
776	INCOMPATIBLE DISPENSING STATUS ('C' OR 'P' CANNOT FOLLOW 'BLANK'). RECORD WITH UNSPECIFIED FILL STATUS IS ON FILE FOR THIS SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'BLANK'). DDPS CANNOT ACCEPT ANOTHER RECORD WITH PARTIAL OR COMPLETE FILL FOR THE SAME DISPENSING EVENT (I.E., DISPENSING STATUS = 'P' OR 'C').
777	DUPLICATE PDE RECORD.
778	PAID DATE < DOS.
779	SUBMITTING PLAN CANNOT REPORT NPP FOR COVERED PART D DRUG.
780	SERVICE PROVIDER ID QUALIFIER MUST BE '01' – NPI OR '07' – NCPDP ON STANDARD CLAIM.
781	SERVICE PROVIDER ID IS NOT ON MASTER PROVIDER FILE.
783	SERVICE PROVIDER ID WAS NOT AN ACTIVE PHARMACY ON DOS.
784	DUPLICATE PDE RECORD, ORIGINALLY SUBMITTED BY A DIFFERENT CONTRACT. (EFFECTIVE NOVEMEBER 2006)
785	DUPLICATE PDE RECORD EXISTS ON THIS FILE. THIS PDE IS NOT SAVED.
998	INTERNAL CMS ISSUE REGARDING CONTRACT/PBP OF RECORD ENCOUNTERED. (EFFECTIVE DECEMBER 2006)
999	INTERNAL CMS SYSTEM ISSUE ENCOUNTERED.

UPDATE CODES

EDIT CODE	EDIT DESCRIPTION
851	THE CONTRACT OF RECORD HAS BEEN UPDATED; A P2P CONDITION *NOW* EXISTS.
852	THE SUBMITTING CONTRACT/PBP IS NOW THE CONTRACT/PBP OF RECORD; A P2P CONDITION *NO LONGER* EXISTS.
853	PBP OF RECORD HAS BEEN UPDATED. THIS PDE *CONTINUES* TO BE A NON-P2P PDE.
854	THE CONTRACT OF RECORD AND PBP OF RECORD HAVE BEEN UPDATED. A *NEW* P2P CONDITION IS ESTABLISHED.
855	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.

DDPS Edit Codes

EDIT CATEGORIES AND DESCRIPTIONS

RANGES	EDIT CATEGORIES	DESCRIPTION
603-659	Missing or Invalid	Straightforward edits identifying invalid or missing values. If blank is a legal value, the missing edit does not apply.
660-669	Adjustment or Deletion	Edits in a hierarchy use nine fields (Contract Number, PBP ID, HICN, Service Provider ID, Service Provider ID Qualifier, Prescription/Service Reference Number, DOS, Fill Number, and Dispensing Status).
670-689	Catastrophic Coverage Code	Edits that test the relationship between Catastrophic Coverage Code and the summary cost fields (GDCA and GDCB), so that allowable reinsurance costs are summed correctly. (Applies only to PDEs for Part D Covered Drugs)
690-699	Cost	Cost edits perform basic accounting functions to confirm that 1.) the summary cost fields and the detail cost fields balance and that 2.) the detail cost fields and payment fields balance. The summary cost field (GDCA) is used to sum allowable reinsurance costs.
700-714	Eligibility	Eligibility edits verify the HICN and the beneficiary's eligibility for Part D. Effective August 2006, DDPS introduced some special editing rules to support Plan to Plan reconciliation.
715-734	Low Income Cost-Sharing Subsidy (LICS)	LICS edits confirm that CMS documents the beneficiary's LICS status and validates that beneficiary cost-sharing never exceeds statutorially defined maximum amounts. Dollars reported in LICS are used to reconcile LICS.
735-754	National Drug Code (NDC)	NDC edits confirm that an NDC exists and that the NDC existed on the date of service. The NDC edits also identify excluded drugs and test for logical relationships between the NDC and Drug Coverage Status Code. Non-covered drugs are excluded from TrOOP, LICS, and payment calculations.
755-774	Drug Coverage Status Code	Edits that test the relationship between non-covered drugs, the Catastrophic Coverage Code field, and dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, and payment calculations.
775-799 900-999	Miscellaneous	Edits on miscellaneous data elements.
851-855	Update Codes	Update codes generate as a result of the P2P Contract/PBP Update. Update codes will be received by Submitting Contracts on a Special Return File. Update codes will only be sent to Submitting Contracts and will not be sent to Updated Contracts of Record or Original Contracts of Record.

MISSING/INVALID

EDIT CODE	EDIT DESCRIPTION
603	HICN IS MISSING. MUST NOT BE BLANK.
604	CARDHOLDER ID IS MISSING.
605	DOB IS AN INVALID DATE. DATES MUST BE IN CCYYMMDD FORMAT.
606	GENDER IS MISSING OR INVALID. GENDER MUST BE EITHER 1 OR 2.
607	DOS IS MISSING OR INVALID. DOS MUST BE IN CCYYMMDD FORMAT AND BE A VALID DATE.
608	DOS MUST BE ON/AFTER 1/1/2006.
609	DOS MUST BE ON OR BEFORE TODAY'S DATE.
610	PAID DATE IS MISSING. MUST NOT BE BLANK FOR FALLBACK PLANS.
611	PAID DATE IS AN INVALID DATE IN CCYYMMDD FORMAT.
612	PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER IS MISSING OR INVALID. PRESCRIPTION NUMBER/SERVICE REFERENCE NUMBER MUST BE NUMERIC.
613	NDC CODE IS MISSING.
614	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.
615	SERVICE PROVIDER ID IS MISSING OR INVALID.
616	FILL NUMBER IS MISSING OR INVALID. FILL NUMBER MUST BE EQUAL TO A VALUE BETWEEN 0 AND 99.
617	DISPENSING STATUS IS INVALID. DISPENSING STATUS MUST BE EITHER A BLANK OR 'P' OR 'C'.
618	COMPOUND CODE IS MISSING OR INVALID. COMPOUND CODE MUST BE EQUAL TO 0, 1, OR 2.

DDPS Edit Codes

MISSING/INVALID (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
619	DAW/PRODUCT SELECTION CODE IS MISSING OR INVALID. DAW/PRODUCT SELECTION CODE MUST BE EQUAL TO VALUE BETWEEN 0 AND 9.
620	QUANTITY DISPENSED IS MISSING OR INVALID. QUANTITY DISPENSED MUST BE ≥ 0.001.
621	DAYS SUPPLY IS MISSING OR INVALID. VALUE MUST BE A VALUE BETWEEN 0 AND 999 DAYS.
622	PRESCRIBER ID QUALIFIER IS MISSING.
623	PRESCRIBER ID QUALIFIER IS INVALID. PRESCRIBER ID QUALIFIER MUST BE EQUAL TO '01' – NPI OR '06' – UPIN OR '08' – STATE LICENSE OR '12' – DEA.
624	PRESCRIBER ID IS MISSING. MUST NOT BE BLANK.
625	DRUG COVERAGE STATUS CODE IS MISSING OR INVALID. VALID VALUES ARE 'C', 'E', AND 'O'.
626	ADJUSTMENT/DELETION CODE IS INVALID. VALID VALUES ARE 'A' FOR ADJUSTMENT AND 'D' FOR DELETION, OR 'BLANK'.
627	NON-STANDARD FORMAT CODE IS INVALID. VALID VALUES ARE 'BLANK', 'B', 'X', OR 'P'.
628	PRICING EXCEPTION CODE IS INVALID. VALID VALUES ARE 'BLANK' OR 'O'.
629	CATASTROPHIC COVERAGE CODE IS INVALID. MUST BE 'BLANK', 'A', OR 'C'.
630	INGREDIENT COST PAID IS MISSING OR INVALID. INGREDIENT COST PAID MUST BE ≥ ZERO.
631	DISPENSING FEE PAID IS MISSING OR INVALID. MUST BE ≥ ZERO.
632	SALES TAX IS MISSING OR INVALID. MUST BE ≥ ZERO.
633	GDCB IS MISSING OR INVALID. MUST BE ≥ ZERO.
634	GDCA IS MISSING OR INVALID. MUST BE ≥ ZERO.
635	PATIENT PAY AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
636	OTHER TrOOP AMOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
637	LICS VALUE IS MISSING OR INVALID. MUST BE ≥ ZERO.
638	PLRO IS MISSING OR INVALID. MUST BE NUMERIC.
639	CPP IS MISSING OR INVALID. MUST BE ≥ ZERO.
640	NPP IS MISSING OR INVALID. MUST BE NUMERIC.
641	FILLER FIELDS MUST BE BLANK (EFFECTIVE AUGUST 2006).
642	STATE-TO-PLAN PDES ARE NOT ALLOWED WITH DATE OF SERVICE AFTER MARCH 31, 2006. (EFFECTIVE DECEMBER 2006)
643	STATE-TO-PLAN PDES ARE NOT ALLOWED WITH NON-COVERD DRUGS. (EFFECTIVE DECEMBER 2006)
644	SERVICE PROVIDER ID QUALIFIER MUST BE '07' FOR STATE-TO-PLAN PDES. (EFFECTIVE DECEMBER 2006)
645	SERVICE PROVIDER ID'5300378' ALLOWED ONLY FOR STATE-TO-PLAN PDES (EFFECTIVE DECEMBER 2006)
646	ESTIMATED REBATE AT POINT OF SALE IS MISSING OR INVALID. FOR SERVICE DATES EFFECTIVE JANUARY 1, 2008 FORWARD, MUST BE ≥ ZERO. FOR SERVICE DATES PRIOR TO 2008, MUST BE ZERO OR SPACES.
647	VACCINE ADMINISTRATION FEE AMOUNT IS MISSING OR INVALID. FOR SERVICE DATES EFFECTIVE JANUARY 1, 2008 FORWARD, MUST BE >ZERO. FOR SERVICE DATES PRIOR TO 2008, MUST BE ZERO OR SPACES.
648	PRESCRIPTION ORIGIN CODE IS INVALID. VALID VALUES ARE, <BLANK>, '0', '1', '2', '3', AND '4'. (EFFECTIVE JANUARY 2009)

ADJUSTMENT/DELETION

EDIT CODE	EDIT DESCRIPTION
660	ADJUSTMENT/DELETION PDE DOES NOT MATCH THE EXISTING PDE RECORD (9 FIELD MATCH).
661	CANNOT ADJUST RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
662	CANNOT DELETE RECORD. EXISTING PDE HAS ALREADY BEEN DELETED.
663	VALUE OF DISPENSING STATUS ON ADJUSTMENT RECORD AND THE RECORD TO BE ADJUSTED MUST BE THE SAME.

DDPS Edit Codes

CATASTROPHIC COVERAGE CODE

EDIT CODE	EDIT DESCRIPTION
670	IF CATASTROPHIC COVERAGE IS 'BLANK', GDCB MUST BE GREATER THAN ZERO.
671	IF CATASTROPHIC COVERAGE IS 'BLANK', GDCA MUST BE ZERO.
672	IF CATASTROPHIC COVERAGE IS 'A', GDCB MUST BE GREATER THAN ZERO.
673	IF CATASTROPHIC COVERAGE IS 'C', GDCA MUST BE GREATER THAN ZERO.
674	IF CATASTROPHIC COVERAGE IS 'C', GDCB MUST BE ZERO.

COST

EDIT CODE	EDIT DESCRIPTION
690	SUM OF COST FIELDS > SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK' OR 'P'.
691	SUM OF GDCB AND GDCA IS NOT EQUAL TO THE SUM OF INGRED COST + DISP FEE + SALES TAX + VACCINE ADMINISTRATION FEE.
692	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK' AND CPP + NPP > 0 AND MEDICARE IS PRIMARY.
693	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'C'.
694	SUM OF INGREDIENT COST, DISPENSING FEE, AND VACCINE ADMINISTRATION FEE MUST BE > ZERO

ELIGIBILITY

EDIT CODE	EDIT DESCRIPTION
700	HICN DOES NOT MATCH AN EXISTING BENEFICIARY.
701	DOB PROVIDED DOES NOT MATCH THE DOB ON CMS FILES.
702	GENDER DOES NOT MATCH THE VALUE ON CMS FILES.
703	DOS CANNOT BE LESS THAN THE DOB.
704	DOS CANNOT BE GREATER THAN THE DATE OF DEATH (DOD) PLUS 32 DAYS.
705	BENEFICIARY MUST BE ENROLLED IN PART D ON THE DOS.
706	THIS DOS DOES NOT FALL IN A VALID P2P PERIOD. BENEFICIARY MUST BE ENROLLED IN THIS CONTRACT ON THE DOS.
707	BENEFICIARY MUST BE ENROLLED IN THIS PART D PLAN BENEFIT PACKAGE ON THE DOS.
708	SUBMITTER CONTRACT DIFFERS FROM CONTRACT OF RECORD; THIS PDE IS SUBJECT TO PLAN TO PLAN RECONCILATION (EFFECTIVE AUGUST 2006). [INFORMATIONAL]
709	SUBMITTER CONTRACT DIFFERS FROM CONTRACT OF RECORD; THIS PDE IS NOT SUBJECT TO PLAN TO PLAN RECONCILIATION (EFFECTIVE AUGUST 2006). PDEs WITH DRUG COVERAGE STATUS CODE OF 'E' OR 'O' ARE NOT ELIGIBLE FOR P2P RECONCILIATION. [INFORMATIONAL]
710	UPDATED HICN (EFFECTIVE AUGUST 2006). [INFORMATIONAL]
712	SUBMITTING CONTRACT/PBP IS NOT THE PRIOR CONTRACT OF RECORD. (EFFECTIVE MAY 2007) [INFORMATIONAL]
713	SUBMITTING CONTRACT/PBP DOES NOT OFFER PART D ON DATE OF SERVICE. (EFFECTIVE DECEMBER 2006)
714	DOS IS GREATER THAN THE DATE OF DEATH (DOD), BUT IS WITHIN THE 32-DAY ALLOWABLE MARGIN. (EFFECTIVE MAY 2007) [INFORMATIONAL]

LOW-INCOME COST-SHARING SUBSIDY (LICS)

EDIT CODE	EDIT DESCRIPTION
715	DOLLARS REPORTED IN LICS ARE GREATER THAN ZERO. HOWEVER, BENEFICIARY IS NOT ELIGIBLE FOR LICS. (APPLIES TO DOS 2007 AND BEYOND)
716	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR INSTITUTIONALIZED LICS BENEFICIARY.
717	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 2 LICS BENEFICIARY.
718	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 1 LICS BENEFICIARY.
719	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED MAXIMUM FOR CATEGORY 4 LICS BENEFICIARY WHO HAS MET DEDUCTIBLE.[INFORMATIONAL]
720	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED CATASTROPHIC MAXIMUM FOR CATEGORY 1 OR CATEGORY 2 LICS BENEFICIARIES WHO HAVE REACHED THE OUT-OF-POCKET THRESHOLD.
721	PATIENT LIABILITY EXCEEDS THE STATUTORIALLY DEFINED CATASTROPHIC MAXIMUM FOR CATEGORY 4 LICS BENEFICIARY WHO HAS REACHED THE OUT-OF-POCKET THRESHOLD.
722	DOLLARS REPORTED IN LICS ARE GREATER THAN ZERO. HOWEVER, BENEFICIARY IS NOT ELIGIBLE FOR LICS SUBSIDY IN CMS SYSTEMS. (APPLIES TO COVERED DRUGS WITH DOS IN 2006) [INFORMATIONAL]

Immediately Actionable PDE Error Code Reports

2007/2008 IMMEDIATELY ACTIONABLE PDE ERROR CODES

CATEGORY	DESCRIPTION	RESOLUTION	CODES
Missing and Invalid Errors	• Errors due to formatting mistakes and data inconsistencies • 600 series adjustment/deletion error codes are excluded from this category	• Determine cause of inconsistency, correct, and resubmit.	603 – 648 670 – 674 690 – 694
Beneficiary Related Errors	• Errors due to beneficiary data inconsistencies	• Correct data issue and resubmit.	700-702
Low Income Cost-Sharing (LICS) Errors	• Errors related to the failure to grant sufficient low income cost-sharing (LICS) subsidies	• Plan cost-sharing for LICS eligible beneficiaries was less generous than the level set by CMS. • Plans should correct the LICS levels in their system, refund beneficiary for excessive cost-sharing • Resubmit PDE with correct LICS cost-sharing amount.	716 – 721
Service Provider ID Errors	• Errors due to service provider ID or service provider ID qualifier mistakes	• Edit 780 - Correct data issue and resubmit. • Edit 783 - CMS bypassing this edit. Plans should resubmit.	780 783
Miscellaneous Errors	• Other errors CMS considers as immediately actionable.	• Confirm Plan Type • Plans should only map CPP/NPP for Enhanced Alternative (EA) plans or plans that were told to submit as EA (e.g., employer plans, payment demonstrations).	779

CONTRACT REPORT DESCRIPTIONS AND NAMING CONVENTIONS

REPORT NAME	DESCRIPTION	NAMING CONVENTION
PDE Verification Summary Report	Provides summary information on PDE that includes submission, rejection, and error resolution statistics.	ContractID_Rejection ErrorSummary_Month_Year
PDE Verification Detail Report	Provides confidential beneficiary information and PDE level detail along with the summary information.	ContractID_Rejection ErrorDetail_Month_Year

Component 1 – PDE Submission Performance Overview		
Metrics	**Description of Metric**	**Corresponding Worksheet Column**
Worksheet 1: The Submission Summary Provides metrics on PDEs submitted by the contract that were ever rejected, still remain unresolved, and have errors immediately actionable by the contract.		
Total PDEs Reject Rate	Represents the percentage of all PDEs submitted by a contract that were ever rejected.	F
Unresolved PDEs Reject Rate	Represents the percentage of all PDEs submitted that were rejected and remain unresolved according to the most recent data available.	H
Unresolved Immediately Actionable Reject Rate	Consists of the percentage of PDEs submitted that remain unresolved and are also immediately actionable by the contract.	J
Immediately Actionable Reject Rate	Represents the percentage of ever rejected PDEs that are immediately actionable.	M

Immediately Actionable PDE Error Code Reports

Component 1 – PDE Submission Performance Overview (continued)

Metrics	Description of Metric	Corresponding Worksheet Column
Worksheet 2: The Immediately Actionable Errors Scorecard Displays a set of metrics that indicate the contract's performance in resolving rejected PDEs with errors that are immediately actionable.		
Immediately Actionable Reject Rate	Reflects the percentage of all PDEs submitted by a contract that are rejected with errors that are immediately actionable.	D
Unresolved Immediately Actionable Reject Rate	Consists of the percentage of PDEs submitted that remain unresolved and are also immediately actionable by the contract.	F
Resolution Rate	Highlights the percentage of PDEs ever rejected with immediately actionable errors that have been resolved by the contract.	H

Worksheet 3: The Immediately Actionable Resubmission Detail

Provides an overview of the PDEs with immediately actionable errors that have not been resolved by the contract according to the most recent data available. Displays metrics for unresolved PDEs that were resubmitted at least once by the contract. Provides analysis on immediately actionable PDEs that have not been resubmitted for timeframes of 30, 60, and 90 days since rejection.

Component 2 – PDE Rejection Errors Overview

Worksheet 1: The Immediately Actionable Resolved Rejected

Provides an analysis, by error code, of immediately actionable PDEs that have been resolved by your contract according to the most recent data available. This sheet summarizes the number of PDEs ever submitted and rejected with a given error code as well as the percent of these submissions that have been resolved and the percent that were resubmitted. Moreover, this sheet provides analysis on the speed at which PDEs with a given error code are resolved by the contract. Using a breakdown of various periods (30, 60, or 90 days) from the date of first rejection until resolution, by error code, it is easy to identify those error codes that are resolved more quickly or slowly relative to others. The financial impact of these resolved PDEs, by error code, is also included in this worksheet.

Worksheet 2: The Immediately Actionable Unresolved Rejected

Provides an overview, by error code, of PDEs with immediately actionable errors that have not been resolved by your contract according to the most recent data available. This sheet summarizes the number of unresolved PDEs submitted, the percentage of these that were ever resubmitted, and the average number of submission per PDE, by error code. This sheet also displays a breakdown for which the PDEs remain unresolved for time frames of 30, 60, or 90 days since the first rejection. The financial impact of these unresolved PDEs, by error code, is also included in this worksheet.

Component 3 – Detailed Error Analysis

Worksheet 1: Error Detail (600-Series – Missing/Invalid Errors)

Provides a frequency by month of the latest process date of unresolved PDEs with this given error code. This breakdown makes it apparent if the latest submission of PDEs rejected with the error code are clustered within a certain month. These worksheets also summarize the financial impact of these PDEs by month.

Worksheet 2: Error Detail (780, 783 – Pharmacy-Related Errors)

Provides a frequency by service provider ID of the unresolved PDEs with this given error code. This worksheet provides an overview of the actual service provider IDs associated with the error code, as well as the range of dates of service on PDEs designated with the error code for a particular service provider ID. These worksheets also summarize the financial impact of these PDEs by Service Provider ID.

Worksheet 3: Error Detail (700, 701, 702 – Beneficiary-Related Errors)

Provides an overview on the HICNs affected by the error along with ranges of the dates of service and submissions dates for which each given HICN appears on unresolved PDEs with the error code. Those users who have been granted access to the detailed version of the reports will be able to review analysis on error codes associated with beneficiary-level issues. The financial impact for each HICN is also displayed in these worksheets.

PART D PAYMENT CALCULATIONS

DIRECT SUBSIDY

Prospective Direct Subsidy

PDS = (STAND_BID * RS_i) – BENE_PREM

Where
PDS = Prospective direct subsidy payment
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RS_i = Initial beneficiary Part D risk score
BENE_PREM = Premium related to the standardized bid amount

Reconciled Direct Subsidy

ADS = (STAND_BID * RS_f) – BENE_PRE

Where
ADS = Actual direct subsidy due
STAND_BID = Approved Part D standardized bid amount (see Plan Bid Pricing Tool)
RS_f = Final beneficiary Part D risk score
BENE_PREM = Premium related to the standardized bid amount

RDS = ADS - PDS

Where
RDS = Reconciliation direct subsidy payment adjustment
PDS = Prospective direct subsidy payment
ADS = Actual direct subsidy payment due

LOW INCOME COST-SHARING SUBSIDY

Monthly Prospective LICS

PLICS = BLICS * LI_ENR

Where
PLICS = Monthly prospective LICS
BLICS = Low income estimate calculated from the approved bid (See Plan Bid Pricing Tool)
LI_ENR = Number of low income beneficiaries enrolled in the month

LICS Reconciliation

RLICS = ALICS - PLICS

Where
RLICS = LICS reconciliation amount
ALICS = Sum of plan-reported actual LICS dollars in the coverage year
PLICS = Sum of all prospective LICS payments (includes any adjusted payments) in the coverage year

REINSURANCE

Prospective Reinsurance Subsidy

PROSP_REINS = BID_REINS * ENR

Where
PROSP_REINS = Monthly prospective reinsurance subsidy
BID_REINS = Reinsurance pmpm estimate in the approved bid (See Plan Bid Pricing Tool)
ENR = Number of beneficiaries enrolled in the month

DIR Ratio

DIR_RATIO = GDCA / (GDCA + GDCB)

Where
GDCA = Gross Drug Costs Above the Out-of-Pocket Threshold
GDCB = Gross Drug Costs Below the Out-of-Pocket Threshold

Reinsurance Portion of DIR

REINS_DIR = DIR_RATIO * NDDIR

Where
REINS_DIR = Reinsurance portion of DIR
NDDIR = Net DIR for Covered Part D drugs

Allowable Reinsurance Cost

ALLOW_REINS = GDCA – REINS_DIR

Where
ALLOW_REINS = Allowable Reinsurance Costs
GDCA = Gross Drug Costs Above the Out-of-Pocket Threshold
REINS_DIR = Reinsurance Portion of DIR

Plan-Level Reinsurance Subsidy

REINS_RECON = REINS_SUBS – PROSP_REINS

Where
REINS_RECON = Reinsurance Reconciliation Amount
REINS_SUBS = Reinsurance Subsidy
PROSP_REINS = Sum of Prospective Monthly Reinsurance Subsidy

Reconciliation Reinsurance Subsidy

REINS_SUBS = ALLOW_REINS*.8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

RISK SHARING

Administrative Cost Ratio Calculation

AC_RATIO = (NON-PHARMACY EXPENSES + GAIN_LOSS) / BASIC_BID

Where
AC_RATIO = Administrative Cost Ratio
NON_PHARM = Non-Pharmacy Expense*
GAIN_LOSS = Gain/(Loss)*
BASIC_BID = Total Basic Bid*

*See Plan Bid Pricing Tool

Plan Target Amount

TARGET= (DS + PARTD_BASIC_PREM) * (1.00 – AC_RATIO)

Where
TARGET = Target amount
DS = Total direct subsidy
PARTD_BASIC_PREM = Beneficiary premiums related to the standardized bid

AC_RATIO = Administrative cost ratio

Risk Threshold Limits (2006 – 2007)

Second threshold lower limit (STLL)	= Target Amount * 0.95
First threshold lower limit (FTLL)	= Target Amount * 0.975
First threshold upper limit (FTUL)	= Target Amount * 1.025
Second threshold upper limit (STUL)	= Target Amount * 1.05

Risk Threshold Limits (2008 – 2011)

Second threshold lower limit (STLL)	= Target Amount * 0.90
First threshold lower limit (FTLL)	= Target Amount * 0.95
First threshold upper limit (FTUL)	= Target Amount * 1.05
Second threshold upper limit (STUL)	= Target Amount * 1.10

Adjusted Allowable Risk Corridor Costs (AARCC)

AARCC = (URCC – REINS_SUBS – NDDIR) / IU

Where
AARCC = Adjusted Allowable Risk Corridor Costs
URCC = Unadjusted Risk Corridor Costs
REINS_SUBS = Reinsurance Subsidy
NDDIR = Net Covered Part D DIR
IU = Induced Utilization ratio

SPECIAL PLAN TYPES

Risk Sharing for Flexible and Fixed Capitated Demonstration Plan

TARGET= (DS + PARTD_BASIC_PREM) * (1.00 – AC_RATIO) + PROSP_REINS

Where
TARGET = Target amount
DS = Total direct subsidy
PARTD_BASIC_PREM = Beneficiary premiums related to the standardized bid
AC_RATIO = Administrative cost ratio
PROSP_REINS = Prospective capitated reinsurance payment

DIRECT AND INDIRECT REMUNERATION

Net Direct and Indirect Remuneration (DIR)

NDDIR = DDIR - ERPOSA

Where
NDDIR = Net DIR for Covered Part D drugs
DDIR = Reported DIR for Covered Part D drugs
ERPOSA = Estimated rebates at point-of-sale