CENTERS for MEDICARE & MEDICAID SERVICES

Prescription Drug Event Job Aids

2011 Regional IT Technical Assistance

A Reclidix & Associates

PART D PAYMENT CALCULATIONS

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 OOP Threshold
GDCB = Gross Drug Costs Below the OOP 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*

*Net DIR is Reported Part D Covered DIR Amount – Total Estimated POS Rebate Amount (see Module entitled Reconciliation)

Allowable Reinsurance Cost

ALLOW_REINS = GDCA – REINS_DIR

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

Reconciliation Reinsurance Subsidy

REINS_SUBS = ALLOW_REINS*0.8

Where
REINS_SUBS = Reinsurance Subsidy
ALLOW_REINS = Allowable Reinsurance Costs

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

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 (2010 – 2012)

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

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

PDE DATA SUBMISSION TIMELINE

NEW CONTRACT EFFECTIVE JANUARY 1, 2011

CY	Data Submission Type	Submission Timeline
2011	EDI Agreement and Submitter Application Deadline	October 31, 2010
2011	Certification Complete*	January 31, 2011
2011	First Production File Due**	March 31, 2011 Comply with routine production timeline thereafter
2011	Production Submissions	Ongoing Monthly Submissions March 30, 2011 – June 29, 2012 • Originals within 30 days following Date of Service or Date Claim Received, whichever is greater. • Adjustments and deletions resubmitted within 90 days following date of discovery. • Rejected records resubmitted within 90 days following receipt of rejected status from CMS.
2011	Final Submission Deadline	June 29, 2012 (11:59 p.m. Eastern Time)
2011	Direct & Indirect Remuneration (DIR) Submission Deadline	June 29, 2012 (11:59 p.m. Pacific Time)

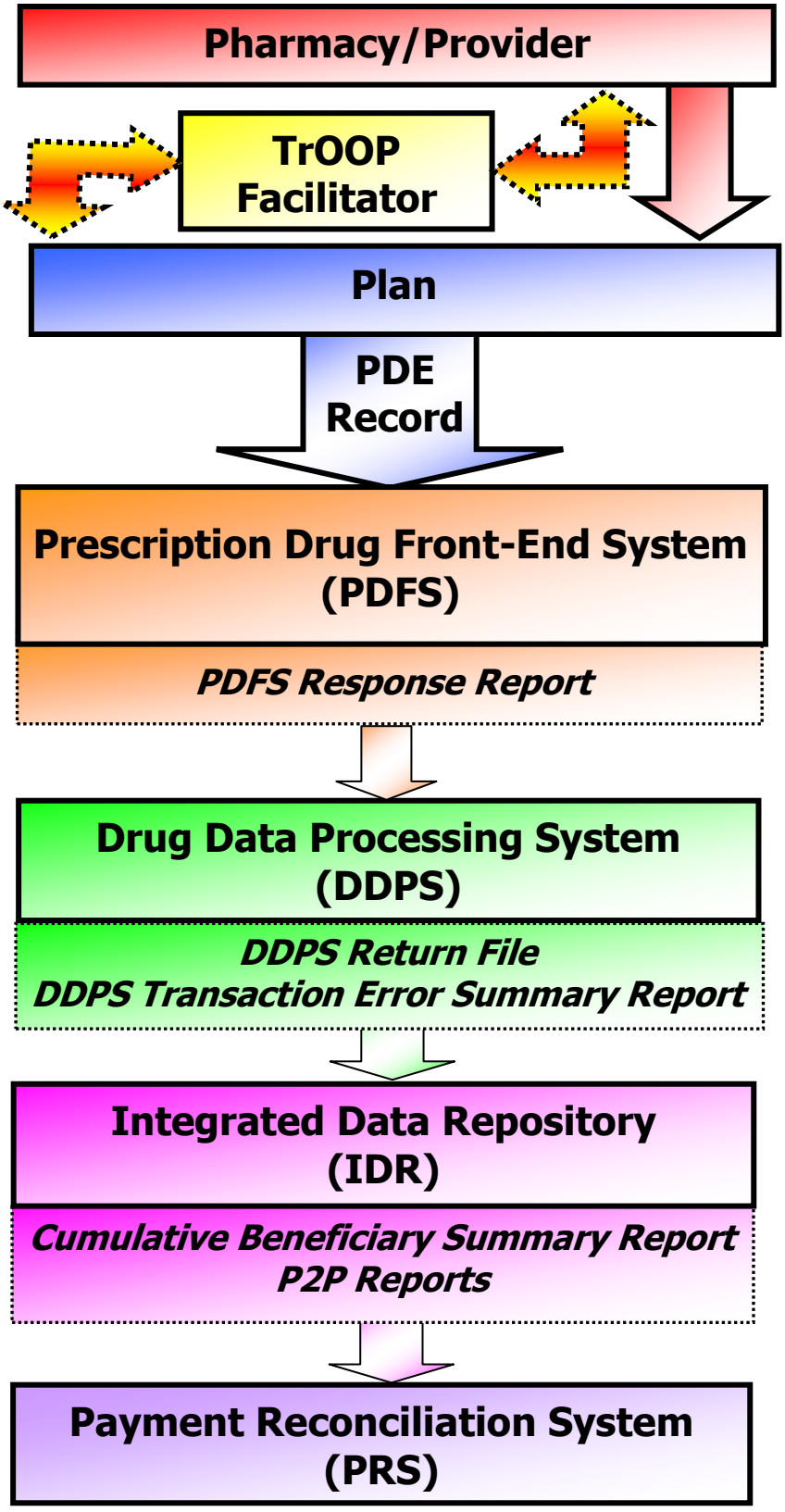
* Only new contracts submitting directly or new third party submitters submitting in CY2011 must complete the testing and certification process.

** Applies to new contract effective at the beginning of the benefit year.

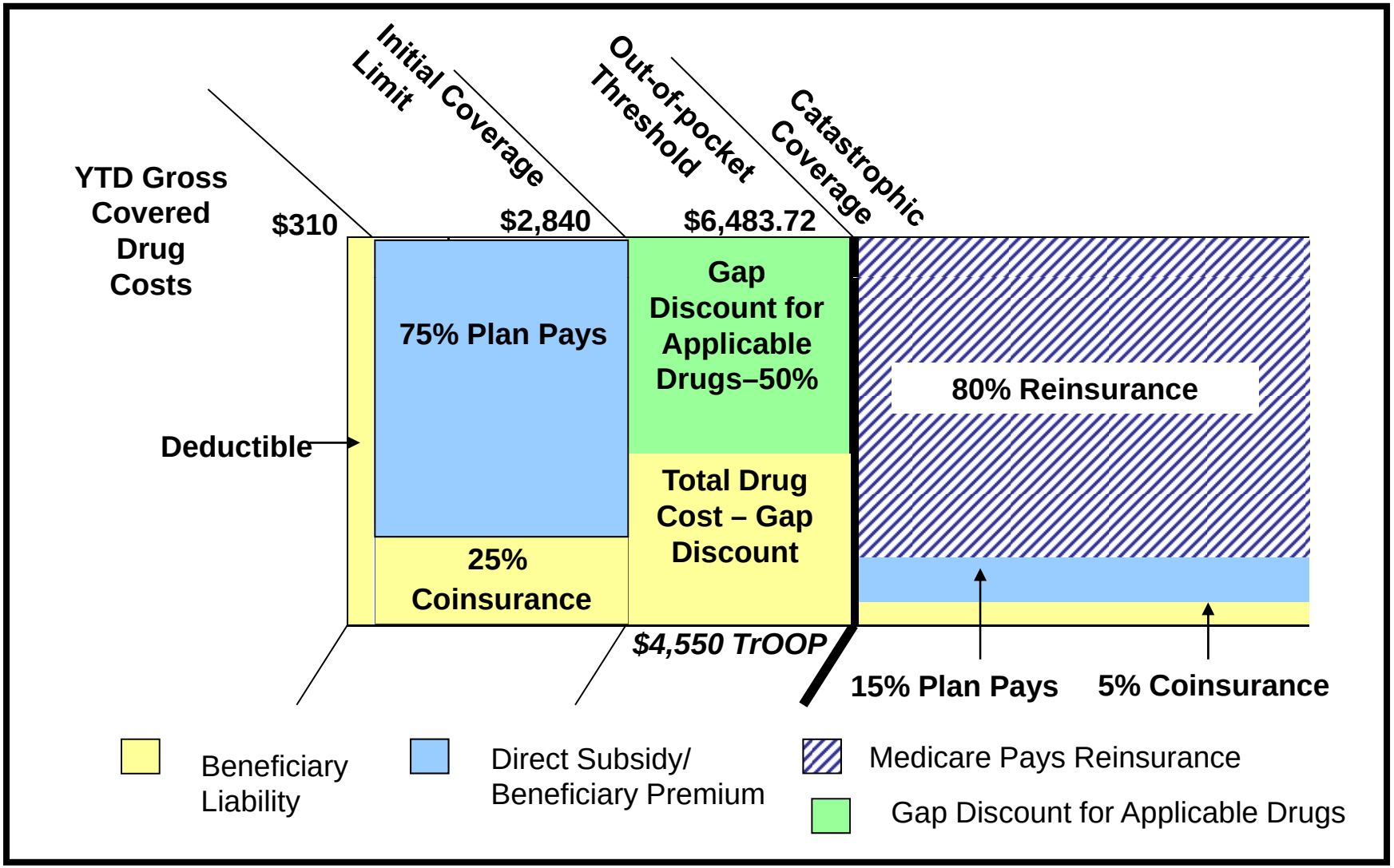
May 2012

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

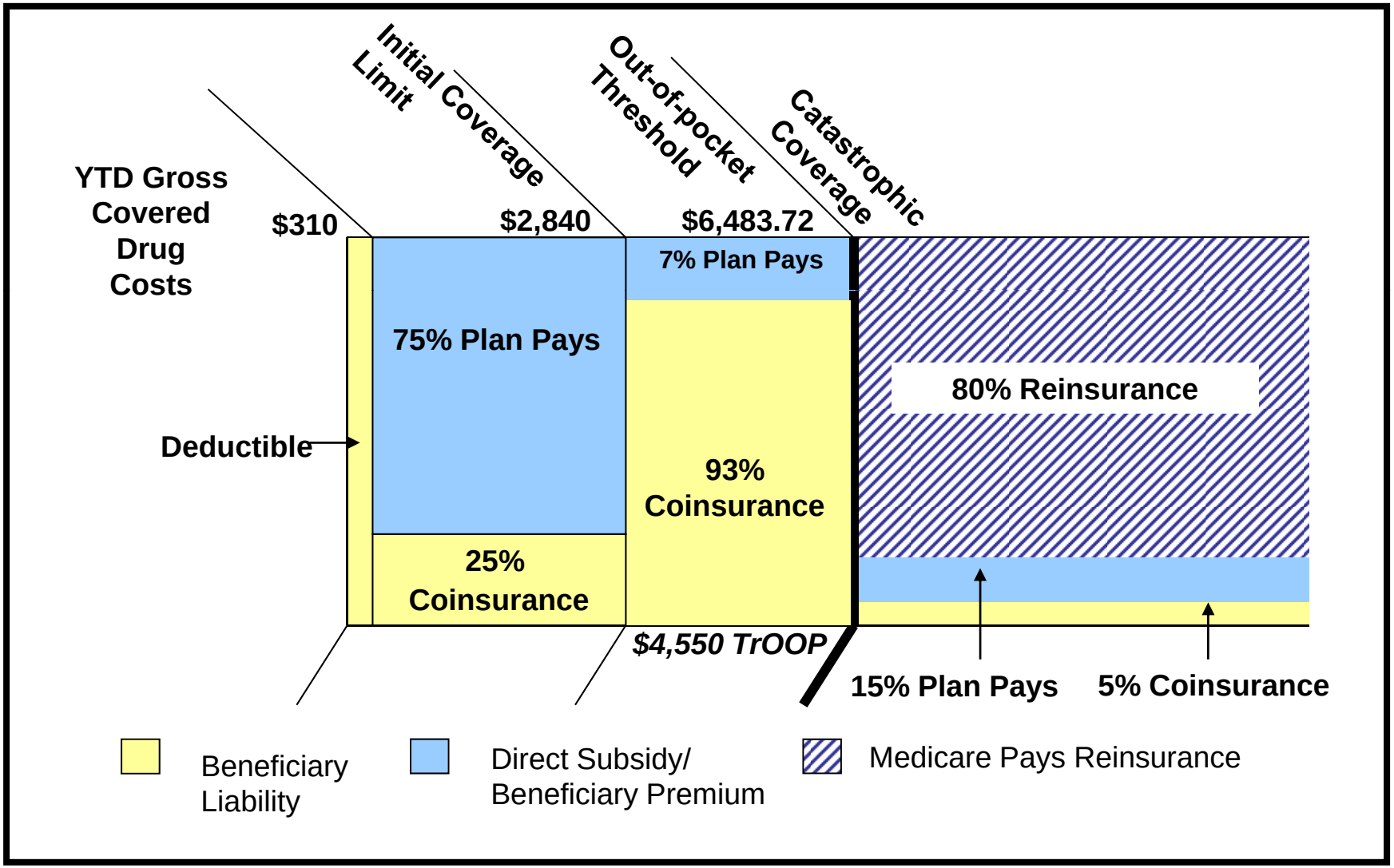
PDE Process Dataflow for Part D Payment Reconciliation



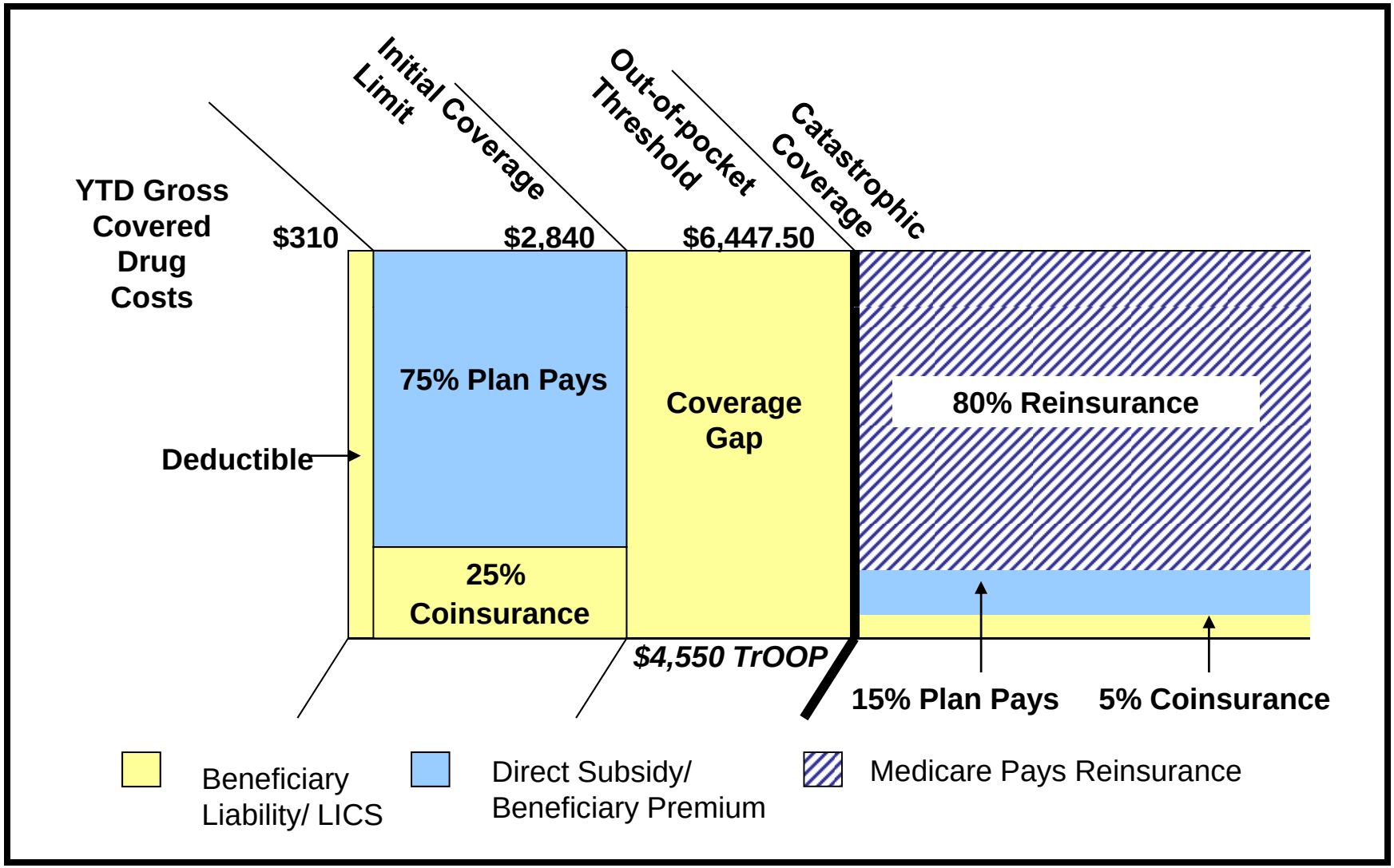
2011 Defined Standard Benefit for Applicable Beneficiaries and Applicable Drugs



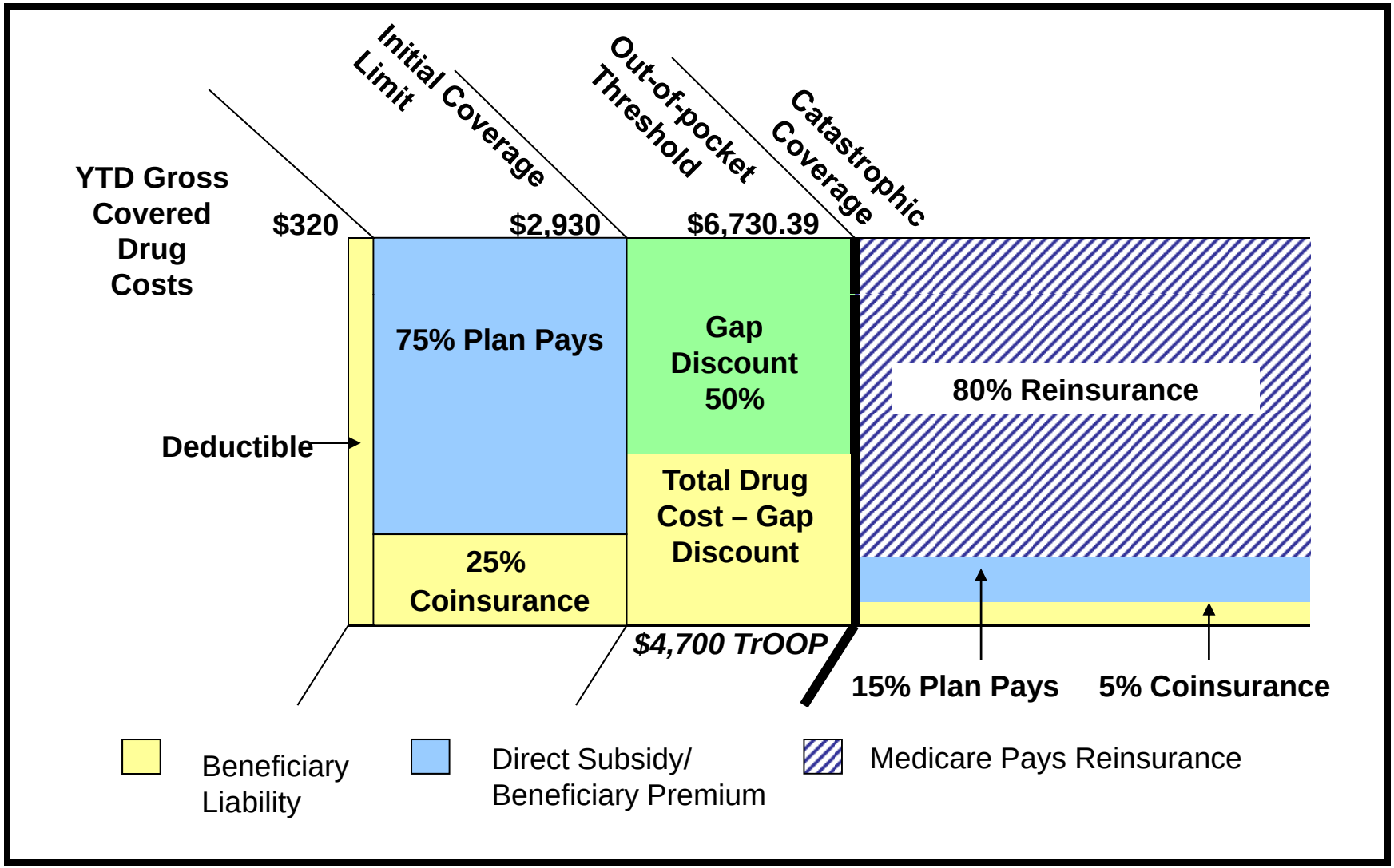
2011 Defined Standard Benefit for Applicable Beneficiaries and Coverage for Generic Drugs



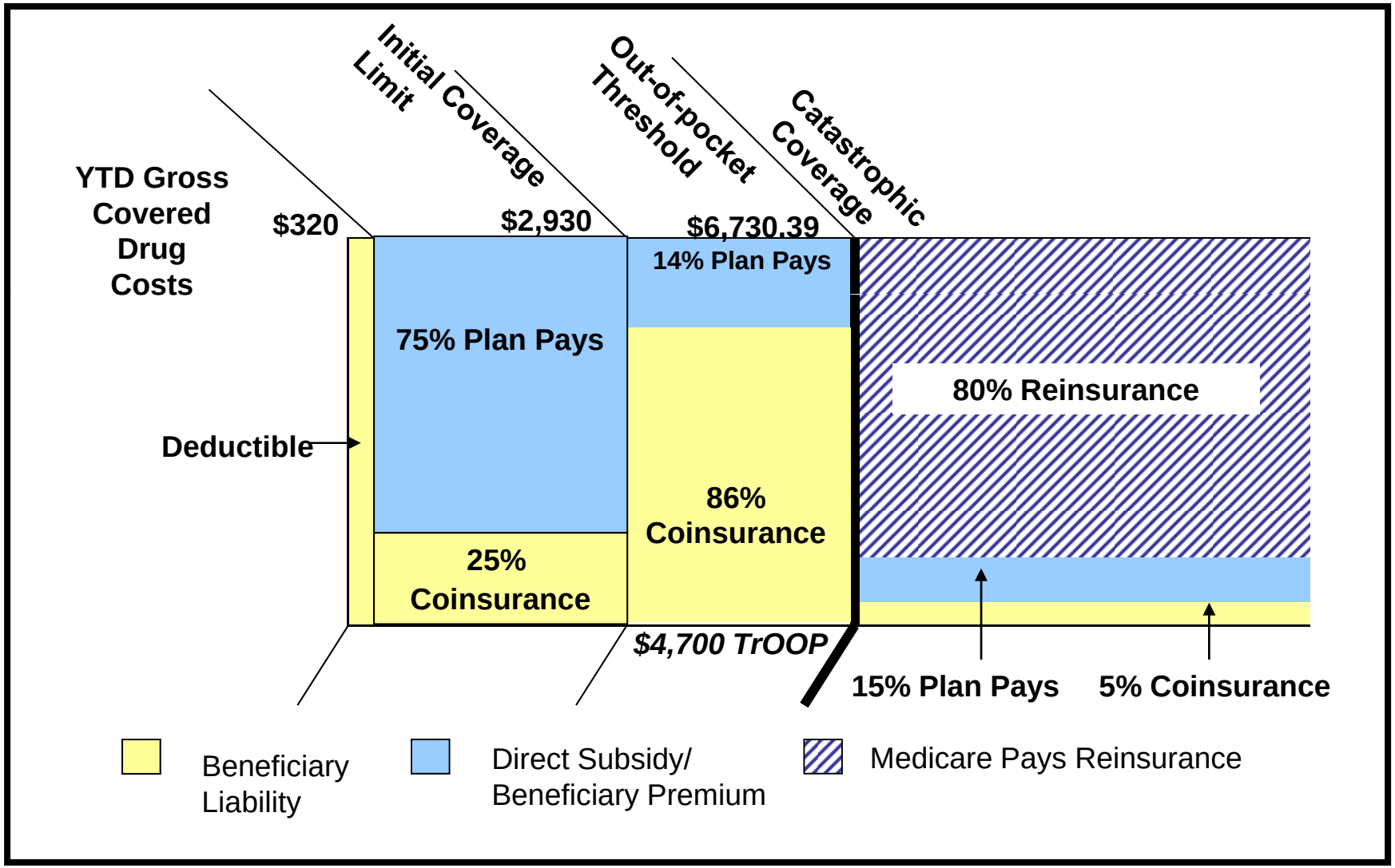
2011 Defined Standard Benefit for Non-Applicable Beneficiaries



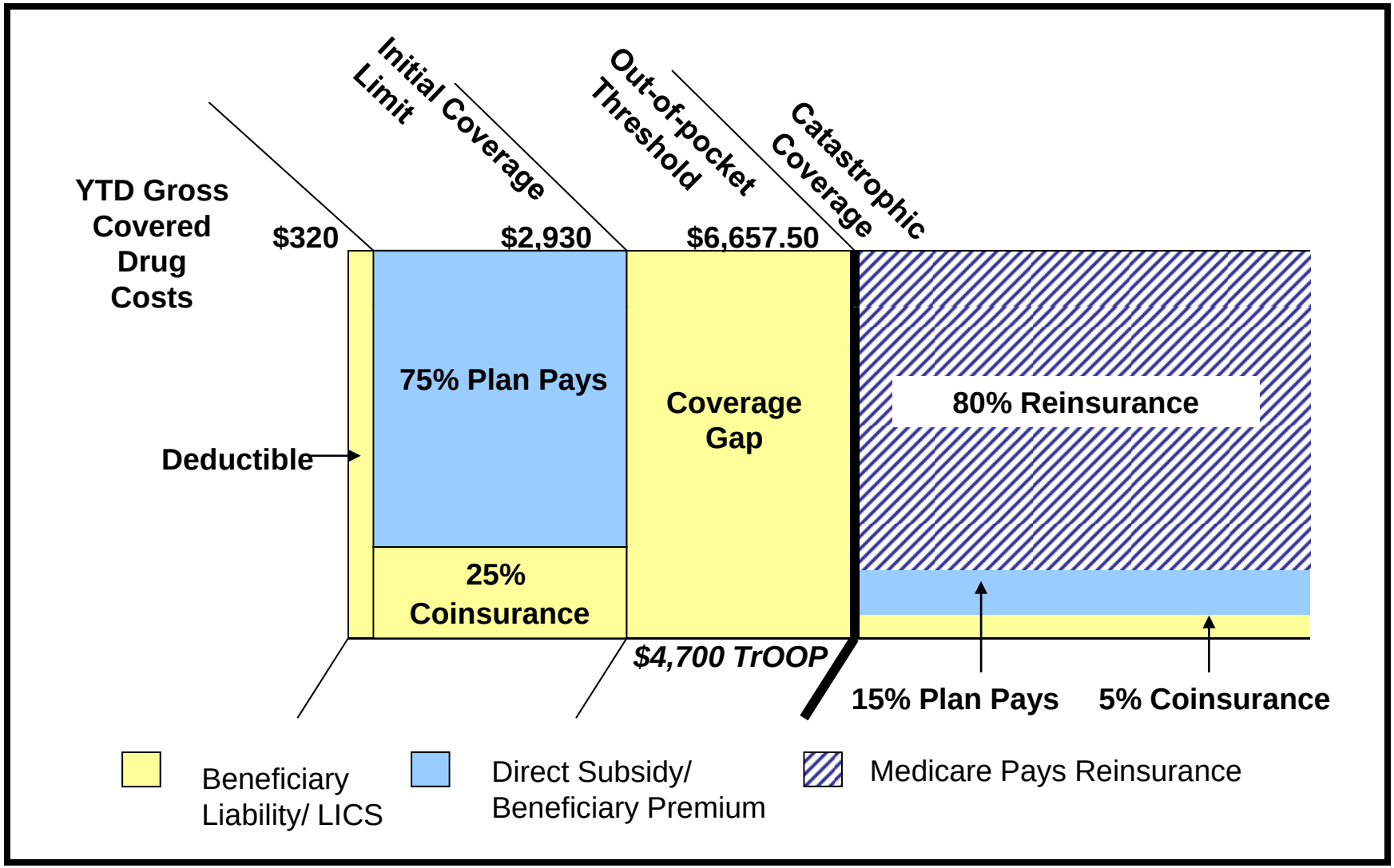
2012 Defined Standard Benefit for Applicable Beneficiaries and Applicable Drugs



2012 Defined Standard Benefit for Applicable Beneficiaries and Coverage for Generic Drugs



2012 Defined Standard Benefit for Non-Applicable Beneficiaries



DEFINED STANDARD BENEFIT

	PHASE	GROSS COVERED DRUG COST	BENEFICIARY COST-SHARING
2011	Deductible	≤$310	100%
	Initial Coverage Phase	>$310 and ≤ $2,840	25%
	Coverage Gap	>$2,840 and ≤ $6,483.72	93% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs
	Catastrophic Coverage	>$6,483.72	Greater of 5% coinsurance or $2.50/$6.30 (generic/brand) co-payment
	TrOOP = $4,550		
2012	Deductible	≤$320	100%
	Initial Coverage Phase	>$320 and ≤ $2,930	25%
	Coverage Gap	>$2,930 and ≤ $6,730.39	86% coinsurance for generic drugs Total Drug Cost – Gap Discount for brand drugs
	Catastrophic Coverage	>$6,730.39	Greater of 5% coinsurance or $2.60/$6.50 (generic/brand) co-payment
	TrOOP = $4,700		

PDE Record Layout

HDR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	DEFINITION/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	DEFINITION/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.

SEE NEXT PAGE

BTR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	DEFINITION/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

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

TLR RECORD

FIELD NO	FIELD NAME	POSITION	PICTURE	DEFINITION/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	DEFINITION/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 – 127	9(12)	00NNNNNNN FIELD WILL BE RIGHT JUSTIFIED AND FILLED WITH 5 LEADING ZEROES. APPLIES TO ALL PDES SUBMITTED JANUARY 1, 2011 AND AFTER.
11	FILLER		128-129	X(2)	SPACES
12	PRODUCT SERVICE ID	407-D7 or 489-TE	130 – 148	X(19)	'MMMMMDDDDPP'
13	SERVICE PROVIDER ID QUALIFIER	202-B2	149 – 150	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	151 – 165	X(15)	STANDARD FORMAT
15	FILL NO	403-D3	166 – 167	9(2)	0=NOT AVAILIABLE 1-99=NUMBER OF FILLS
16	DISPENSING STATUS	343-HD	168 – 168	X(1)	<BLANK> FOR 2011 FORWARD VALID VALUES PRIOR TO 2011: <BLANK>=NOT SPECIFIED 'P'=PARTIAL FILL 'C'=COMPLETION OF PARTIAL FILL
17	COMPOUND CODE	406-D6	169 – 169	9(1)	0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND (MULTIPLE)
18	DISPENSE AS WRITTEN (DAW)	408-D8	170 – 170	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	171 – 180	9(7)V999	# OF UNITS, GRAMS, MILILITER, OTHER.
20	FILLER		181 – 182	X(2)	SPACES
21	DAYS SUPPLY	405-D5	183 – 185	9(3)	0-999
22	PRESCRIBER ID QUALIFIER	466-EZ	186 – 187	X(2)	'01'=NPI '06'=UPIN '08'=STATE LICENCE NO '12'=DEA #

DET RECORD (continued)

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	DEFINITION/VALUE
23	PRESCRIBER ID NO	411-DB	188 – 202	X(15)	
24	DRUG COVERAGE STATUS CODE		203 – 203	X(1)	'C'=COVERED 'E'=ENHANCED 'O'=OTC DRUGS
25	ADJUSTMENT/DELETION CODE		204 – 204	X(1)	'A'=ADJUSTMENT 'D'=DELETION <BLANK>=ORIGINAL PDE RECORD
26	NON-STANDARD FORMAT CODE		205 – 205	X(1)	'X'=X12 837 'B'=BENEFICIARY SUBMITTED CLAIM 'C'=COB CLAIM 'P'=PAPER CLAIM FROM PROVIDER <BLANK>=NCPDP FORMAT
27	PRICING EXCEPTION CODE		206 – 206	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
28	CATASTROPHIC COVERAGE CODE		207 – 207	X(1)	OPTIONAL BEGINNING 2011 'A'=ATTACHMENT POINT MET ON THIS EVENT 'C'=ABOVE ATTACHMENT POINT <BLANK>=ATTACHMENT POINT NOT MET
29	INGREDIENT COST PAID	506-F6	208 – 215	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
30	DISPENSING FEE PAID	507-F7	216 – 223	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
31	AMOUNT ATTRIBUTED TO SALES TAX		224 – 231	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
32	GDCB		232 – 239	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
33	GDCA		240 – 247	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
34	PATIENT PAY AMOUNT	505-F5	248 – 255	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
35	OTHER TrOOP AMOUNT		256 – 263	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
36	LICS AMOUNT		264 – 271	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
37	PLRO		272 – 279	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
38	CPP		280 – 287	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
39	NPP		288 – 295	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
40	ESTIMATED REBATE AT POS		296 – 303	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
41	VACCINE ADMINISTRATION FEE		304 – 311	S9(6)V99	ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
42	PRESCRIPTION ORIGIN CODE	419-DJ	312 – 312	X(1)	VALID VALUES PRIOR TO 2010: <BLANK> '0'=NOT SPECIFIED '1'=WRITTEN '2'=TELEPHONE '3'=ELECTRONIC '4'=FACSIMILE VALID VALUES 2010 FORWARD: VLAUES = 1-4
43	DATE ORIGINAL CLAIM RECEIVED		313 – 320	9(8)	<BLANK> OR ZEROS PRIOR TO JANUARY 1, 2011 CCYYMMDD
44	CLAIM ADJUDICATION BEGAN TIMESTAMP		321 – 346	X(26)	<BLANK> OR ZEROS PRIOR TO JANUARY 1, 2011 CCYYMMDD GREENWICH MEAN TIME
45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR		347 – 355	S9(6)V99	<BLANK> OR ZEROS PRIOR TO JANUARY 1, 2011 ACTUAL SUM OR ZERO DOLLAR AMOUNT; NO DECIMALS
46	TRUE OUT-OF-POCKET ACCUMULATOR		356 – 363	S9(6)V99	<BLANK> OR ZEROS PRIOR TO JANUARY 1, 2011 ACTUAL SUM OR ZERO DOLLAR AMOUNT; NO DECIMALS

DET RECORD (continued)

FIELD NO	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	DEFINITION/VALUE
47	BRAND/GENERIC CODE		364 – 364	X(1)	<BLANK> PRIOR TO JANUARY 1, 2011 'B'=BRAND 'G'=GENERIC <BLANK> (FOR NON-COVERED DRUGS)
48	BEGINNING BENEFIT PHASE		365 – 365	X(1)	<BLANK> PRIOR TO JANUARY 1, 2011 'D'=DEDUCTIBLE 'N'=INITIAL COVERAGE PERIOD 'G'=COVERAGE GAP 'C'=CATASTROPHIC <BLANK> (FOR NON-COVERED DRUGS)
49	ENDING BENEFIT PHASE		366 – 366	X(1)	<BLANK> PRIOR TO JANUARY 1, 2011 'D'=DEDUCTIBLE 'N'=INITIAL COVERAGE PERIOD 'G'=COVERAGE GAP 'C'=CATASTROPHIC <BLANK> (FOR NON-COVERED DRUGS)
50	REPORTED GAP DISCOUNT		367 – 374	S9(6)V99	<BLANK> OR ZEROS PRIOR TO JANUARY 1, 2011 ACTUAL OR ZERO DOLLAR AMOUNT; NO DECIMALS
51	TIER		375 – 375	X(1)	<BLANK> PRIOR TO JANUARY 1, 2011 VALUES=1-6 <BLANK> (FOR NON-COVERED DRUGS)
52	FORMULARY CODE		376 – 376	X(1)	<BLANK> PRIOR TO JANUARY 1, 2011 'F'=FORMULARY 'N'-NON-FORMULARY <BLANK> (FOR NON-COVERED DRUGS)
53	GAP DISCOUNT PLAN OVERRIDE CODE		377 – 377	X(1)	FUTURE USE – VALUES TBD CURRENT VALID VALUE=<BLANK>
54	FILLER		378 – 407	X(30)	SPACES
55	CMS CALCULATED GAP*		408 – 415	S9(6)V99	SPACES
56	PBP OF RECORD*		416 – 418	X(3)	SPACES
57	ALTERNATE SERVICE PROVIDER ID QUALIFIER*		419 – 420	X(2)	SPACES
58	ALTERNATE SERVICE PROVIDER ID*		421 – 435	X(15)	SPACES
59	ORIGINAL SUBMITTING CONTRACT*		436 – 440	X(5)	SPACES
60	P2P CONTRACT OF RECORD*		441 – 445	X(5)	SPACES
61	CORRECTED HICN*		446 – 465	X(20)	SPACES
62	ERROR COUNT*		466 – 467	9(2)	SPACES
63-72	ERROR CODE FIELDS*		468 – 497	X(3)	SPACES
73	EXCLUSION REASON CODE*		498 – 500	X(3)	SPACES
74	FILLER		501 – 512	X(12)	SPACES

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

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**
2011	2	Deemed FBDE* with income ≤ 100% FPL**	No	$1.10-generic $3.30-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 $6,680 ($10,020 if married)##	No	$2.50-generic $6.30-brand	$0
	4	LIS applicant with income <150% FPL** with resources between $7,500-$11,500 ($12,640-$25,260 if married)##	Yes&/$63	15%	$2.50-generic $6.30-brand
	3	Deemed an institutionalized FBDE*	No	$0	$0
2012	2	Deemed FBDE* with income ≤ 100% FPL**	No	$2.60-generic $6.50-brand	$0
	1	Deemed SSI*** recipient, MSP# participant, or FBDE* with income >100% FPL or LIS applicant with income <135% FPL** resources amounts for 2012 available in fall of 2011##	No	$2.60-generic $6.50-brand	$0
	4	LIS applicant with income <150% FPL** with resources amounts for 2012 available in fall of 2011)	Yes&/$65	15%	$2.60-generic $6.50-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.

MAPPING TO THE DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR NON-LI BENEFICIARIES

	Rule #	YTD GROSS COVERED DRUG COST	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
2011	1	≤ $310	0%
	2	> $310 and ≤ $2,840	75%
	3	> $2,840 and ≤ $6,483.72	Applicable drugs 0% Non-applicable drugs 7%
	4	> $6,483.72 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)
2012	1	≤ $320	0%
	2	> $320 and ≤ $2,930	75%
	3	> $2,930 and ≤ $6,730.39	Applicable drugs 0% Non-applicable drugs 14%
	4	> $6,730.39 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.60/$6.50)

MAPPING TO THE DEFINED STANDARD BENEFIT TO CALCULATE CPP VERSUS EACS FOR LI BENEFICIARIES

	Rule #	YTD GROSS COVERED DRUG COST	PERCENTAGE TO CALCULATE DEFINED STANDARD BENEFIT
2011	1	≤ $310	0%
	2	> $310 and ≤ $2,840	75%
	3	> $2,840 and ≤ $6,447.50	0%
	4	> $6,447.50 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.50/$6.30)
2012	1	≤ $320	0%
	2	> $320 and ≤ $2,930	75%
	3	> $2,930 and ≤ $6,657.50	0%
	4	> $6,657.50 and ≤ OOP threshold	15%
	5	>OOP Threshold	Lesser of 95% or (Gross Covered Drug Cost - $2.60/$6.50)

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

EDIT CATEGORIES AND DESCRIPTIONS

RANGES	EDIT CATEGORIES	DESCRIPTION
603-659, 831	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 using 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	Edits that test the relationship between the TrOOP Accumulator and the OOP Threshold (2011 and forward or Catastrophic Coverage Code for DOS prior to 2011) and the summary cost fields for GDCB and Gross Drug Costs Above the Out-of-Pocket Threshold (GDCA), 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 for GDCA is used to sum allowable reinsurance costs.
700-714	Eligibility	Eligibility edits verify the HICN and the beneficiary's eligibility for Part D and enrollment in a Part D plan. Plan enrollment must be accurate because payment calculations including Plan to Plan reconciliation are summarized at the plan level.
715-734	Low Income Cost-sharing (LICS)	LICS edits confirm that CMS documents the beneficiary's LICS status and validates that beneficiary cost-sharing never exceeds statutorily 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 True Out-of-Pocket Costs (TrOOP), LICS, and payment calculations.
755-774	Drug Coverage Status Code	Edits that test the relationship between non-covered drugs, the Beginning and Ending Benefit Phase and Accumulator fields, and other dollar fields, so that non-covered drugs are not inadvertently included in TrOOP, LICS, Reported Gap Discount, and payment calculations.
775-799, 900-999	Miscellaneous	Edits on miscellaneous data elements.
851-855	P2P Phase III Retro Enrollment (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.
865-899	Gap Discount	Edits confirm the Reported Gap Discount field with other data reported on the PDE.

DDPS Edit Codes*

**Edits shaded in gray are new.*

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. FOR DOS PRIOR TO 1/1/2011, DISPENSING STATUS MUST BE EITHER A BLANK OR 'P' OR 'C'. FOR DOS 1/1/2011 AND FORWARD, DISPENSING STATUS MUST BE BLANK.
618	COMPOUND CODE IS MISSING OR INVALID. COMPOUND CODE MUST BE EQUAL TO 0, 1, OR 2.
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', 'P', 'S', OR 'C',
628	PRICING EXCEPTION CODE IS INVALID. VALID VALUES ARE 'BLANK', 'O', OR 'M'.
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).

DDPS Edit Codes

MISSING/INVALID (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
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'.
649	PRESCRIPTION ORIGIN CODE IS INVALID. VALID VALUES FOR ORIGINAL FILL STANDARD FORMATS ARE '1', '2', '3', AND '4'.
650	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 DOS. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES.
651	CLAIM ADJUDICATION BEGAN TIMESTAMP IS MISSING OR INVALID FOR DOS 1/1/ 2011 AND FORWARD, MUST BE A VALID DATE IN CCYY-MM-DD-HH.MM.SS.MMMMMM FORMAT. CANNOT BE A FUTURE DATE OR LESS THAN THE DOS. FOR DOS PRIOR TO 1/1/2011, MUST BE ZEROS OR SPACES.
652	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.
653	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.
654	BRAND/GENERIC CODE IS MISSING OR INVALID. VALID VALUES ARE 'B' FOR BRAND AND 'G' FOR GENERIC.
655	BEGINNING BENEFIT PHASE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'D' FOR DEDUCTIBLE, 'N' FOR INITIAL COVERAGE PHASE, 'G' FOR COVERAGE GAP, AND 'C' FOR CATSTROPHIC. FOR DOS PRIOR TO 1/1/2011, MUST BE BLANK.
656	ENDING BENEFIT PHASE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'D' FOR DEDUCTIBLE, 'N' FOR INITIAL COVERAGE PHASE, 'G' FOR COVERAGE GAP, AND 'C' FOR CATSTROPHIC. FOR DOS PRIOR TO 1/1/2011, MUST BE BLANK.
657	REPORTED GAP DISCOUNT IS MISSING OR INVALID. MUST BE ≥ ZERO.
658	TIER IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, MUST BE BLANK OR A NUMERIC VALUE FROM 1-6. FOR DOS PRIOR TO 1/1/2011, MUST BE 'BLANK'.
659	GAP DISCOUNT PLAN OVERRIDE CODE IS INVALID. MUST BE BLANK.
831	FORMULARY CODE IS MISSING OR INVALID. FOR DOS 1/1/2011 AND FORWARD, VALID VALUES ARE 'F' FOR FORMULARY AND 'N' FOR NON-FORMULARY. FOR DOS PRIOR TO 1/1/2O11, MUST BE BLANK.

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.
664	ADJUSTMENT OR DELETION LI NET PDES SUBMITTED 1/1/2011 AND FORWARD, THE DATE ORIGNAL CLAIM RECEIVED MUST EQUAL THE DATE ORIGINAL CLAIM RECEIVED SUBMITTED ON THE ORIGINAL.

DDPS Edit Codes

CATASTROPHIC COVERAGE CODE

EDIT CODE	EDIT DESCRIPTION
670	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 TROOP ACCUMULATOR < OOP THRESHOLD, GDCB MUST BE GREATER THAN ZERO.
671	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE = 'BLANK', GDCA MUST BE ZERO. FOR DOS 1/1/2011 AND FORWARD, IF (TROOP ACCUMULATOR+PATIENT PAY+OTHER TROOP+REPORTED GAP DISCOUNT+LICS) ≤ OOP THRESHOLD, GDCA MUST BE ZERO.
672	FOR DOS PRIOR TO 1/1/2011, IF CATASTROPHIC COVERAGE CODE IS 'A', GDCB MUST BE GREATER THAN ZERO.
673	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 TROOP ACCUMULATOR = OOP THRESHOLD GDCA MUST BE GREATER THAN ZERO.
674	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 TROOP ACCUMULATOR = OOP THRESHOLD GDCB MUST BE ZERO.
675	ON PDE THAT STRADDLES THE OUT-OF-POCKET THRESHOLD WHERE LICS IS GREATER THAN ZERO, CPP MUST BE 95% OF GDCA.

COST

EDIT CODE	EDIT DESCRIPTION
690	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'.
691	SUM OF GDCB AND GDCA IS NOT EQUAL TO THE SUM OF INGREDEDIENT COST + DISPENSING FEE + SALES TAX + VACCINE ADMINISTRATION FEE AND MEDICARE IS PRIMARY.
692	SUM OF COST FIELDS < SUM OF PAYMENT FIELDS +/- ROUNDING ERROR AND DISPENSING STATUS IS 'BLANK'.
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
695	NPP AMOUNT MUST BE ZERO FOR LI NET PDES.
696	TRUE OUT-OF-POCKET ACCUMULATOR CANNOT BE GREATER THAN TOTAL GROSS COVERED DRUG COST ACCUMULATOR.

ELIGIBILITY

EDIT CODE	EDIT DESCRIPTION
700	HICN DOES NOT MATCH AN EXISTING BENEFICIARY.
701	DOB PROVIDED DOES NOT MATCH THE DOB ON MBD.
702	GENDER DOES NOT MATCH THE VALUE ON MBD.
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.(EDIT DISABLED FOR POS PLANS)
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	EVEN THOUGH SUBMITTING CONTRACT DOES NOT EQUAL 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. [INFORMATIONAL]
710	THE BENEFICIARY HICN HAS CHANGED ACCORDING TO CMS RECORDS; USE THE CORRECTED HICN FOR FUTURE SUBMISSIONS. [INFORMATIONAL]
711	PACE PLANS CANNOT SUBMIT PLAN TO PLAN PDES
712	SUBMITTING CONTRACT WAS NOT PRIOR CONTRACT OF RECORD FOR THIS PLAN TO PLAN PERIOD. [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]

DDPS Edit Codes

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 LOW INCOME BENEFICIARY.
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. PLANS MUST HAVE DOCUMENTED EVIDENCE TO SUBSTANTIATE LICS. [INFORMATIONAL]

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	NDC IDENTIFIES A PART D NON-COVERABLE DRUG.
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.
743	DRUG COVERAGE STATUS CODE MUST BE 'C' FOR LI NET PDES
744	DOS 1/1/2011 AND FORWARD, THIS DRUG IS NOT COVERED UNDER PART D BECAUSE THE FDA-ASSIGNED MARKETING CATEGORY IS NDA OR BLA, AND NO MEDICARE COVERAGE GAP DISCOUNT PROGRAM AGREEMENT IS ON FILE FOR THE MANUFACTURER RESPONSIBLE FOR THIS LABELER CODE.

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 STATUS CODE IS 'O' AND PRICING EXCEPTION CODE <>'M', THEN PATIENT PAY AMOUNT, LICS, OTHER TrOOP, PLRO, AND CPP MUST EACH 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.
764	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TOTAL GROSS COVERED DRUG COST ACCUMULATOR MUST BE BLANKS OR ZEROS.
765	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TRUE OUT-OF-POCKET ACCUMULATOR MUST BE BLANKS OR ZEROS.
766	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE BEGINNING BENEFIT PHASE MUST BE BLANK.

DDPS Edit Codes

DRUG COVERAGE STATUS CODE (CONTINUED)

EDIT CODE	EDIT DESCRIPTION
767	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE ENDING BENEFIT PHASE MUST BE BLANK.
768	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE REPORTED GAP DISCOUNT MUST BE BLANKS OR ZEROS.
769	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE GAP DISCOUNT OVERRIDE CODE MUST BE BLANK.
770	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE TIER MUST BE BLANK.
771	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE FORMULARY CODE MUST BE BLANK.
772	IF DRUG COVERAGE STATUS CODE IS 'E' OR 'O', THEN THE BRAND/GENERIC CODE MUST BE BLANK.

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. DUPLICATE PDE RECORD EXISTS IN DDPS DATA WAREHOUSE.
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.
786	BEGINNING AND ENDING BENEFIT PHASE COMBINATION IS INVALID.
787	BEGINNING AND ENDING BENEFIT PHASE COMBINATION DOES NOT MATCH THE TRUE OUT-OF-POCKET ACCUMULATOR AND/OR TOTAL GROSS COVERED DRUG COST ACCUMULATOR. [BYPASSED FOR EGWP PLANS] [INFORMATIONAL]
788	DDPS NO LONGER ACCEPTS PDES WITH DOS BEFORE 1/1/2008. [BYPASSED FOR LI NET]
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.

GAP DISCOUNT

EDIT CODE	EDIT DESCRIPTION
865	BENEFICIARIES ELIGIBLE FOR THE LOW INCOME COST SHARING SUBSIDY ON THE DOS ARE NOT ELIGIBLE TO RECEIVE A COVERAGE GAP DISCOUNT.
866	MSP AND COB CLAIMS ARE NOT ELIGIBLE 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.
868	SERVICE PROVIDER ID QUALIFER CANNOT BE '99' WHEN PDE REPORTS THE COVERAGE GAP DISCOUNT.
869	NO PORTION OF THE CLAIM IS IN THE COVERAGE GAP; THEREFORE THE COVAGE GAP DISOUCNT DOES NOT APPLY.
870	REPORTED GAP DISCOUNT <> CMS CALCULATED GAP DISCOUNT +/- 0.05.
871	REPORTED GAP DISCOUNT EXCEEDS AMOUNT ESTIMATED BY CMS +/- 0.05.
872	REPORTED GAP DISCOUNT IS LESS THAN OR EQUAL TO AMOUNT ESTIMATED BY CMS. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. ESIMATION NECESSARY BECAUSE THE ACCUMULATOR AMOUNTS DID NOT AGREE WITH THE BENEFIT PHASE VALUES. [INFORMATIONAL]
873	FOR DOS 1/1/2011 FORWARD, IF DRUG COVERAGE STATUS CODE IS 'C' AND GDCB IS ZERO, REPORTED GAP DISCOUNT MUST BE ZERO.
874	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.
875	CLAIMS SUBMITTED WITH COMPOUND DURGS ARE NOT ELIGIBLE TO RECEIVE THE COVERAGE GAP DISCOUNT.
876	REPORTED GAP DISCOUNT (MINUS ROUNDING ERROR) IS LESS THAN THE DISCOUNT AMOUNT ESTIMATED BY CMS, PROVIDED THAT NPP INCLUDES SUPPLEMENTAL BENEFITS IN THE COVERAGE GAP, THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]
877	REPORTED GAP DISCOUNT +/- ROUNDING ERROR EQUALS THE DISCOUNT AMOUNT ESTIMATEDY BY CMS, PROVIDED THAT NPP REPORTS SUPPLEMENTAL BENEFITS IN OTHER BENEFIT PHASES EXCLUDING THE COVERAGE GAP. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]
878	REPORTED GAP DISCOUNT IS ZERO. NO GAP DISCOUNT APPLIES WHEN A PDE STRADDLES TWO ADJOINING CO-PAY BENEFIT PHASES AND THE SECOND BENEFIT PHASE IS THE COVERAGE GAP. THIS PDE MAY BE SUBJECT TO ADDITIONAL SCRUTINY. [INFORMATIONAL]
879	REPORTED COVERAGE GAP DISCOUNT IS ZERO AND GENERIC COST SHARING IS REPORTED FOR GAP DISCOUNT ELIGIBLE PDE.

REPORTED GAP DISCOUNT

A Coverage Gap Discount is calculated on the PDE when the following criteria are met:
1. The beneficiary is an applicable beneficiary
2. The drug is an applicable drug
3. The PDE falls partially or completely in the coverage gap phase

The steps to populate the PDE that meets the above criteria are:
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 the dispensing fee and the vaccine administration fee.

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

4. **Determine beneficiary cost-sharing:** For claims falling squarely in the coverage gap with no other secondary health insurance, beneficiary cost-sharing is Total Drug Cost less Gap Discount. If the beneficiary has other secondary health insurance, the other secondary health insurance reduces beneficiary cost-sharing remaining after the Gap Discount is applied. In Straddle claims beneficiary cost-sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

5. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

6. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)

Coverage for Generic Drugs in the Coverage Gap

The steps to populate the PDE fields on a claim for a generic Part D covered drug that falls completely or partially in the coverage gap are:
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.

2. **Determine beneficiary cost-sharing:** For claims falling squarely in the coverage gap with no other secondary health insurance, the non-LI beneficiary cost-sharing is 93% of the Total Drug Cost. In straddle claims, beneficiary Cost-Sharing is the sum of beneficiary cost-sharing in the gap plus beneficiary cost-sharing from other benefit phases.

3. **Calculate Covered and non-Covered Portion of Plan Paid cost-sharing:** (using existing calculations)

4. **Update Gross Covered Drug Cost Accumulator and TrOOP Accumulator:** (in preparation for adjudicating the next claim)