



Centers for Medicare & Medicaid Services

Module 03: Data Format

2025 Prescription Drug Event (PDE) Participant Guide

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1. Purpose

This module describes the processes required to collect and submit Prescription Drug Event (PDE) data to the Centers for Medicare & Medicaid Services (CMS), a description of the PDE file structure and PDE record layout, and instructions for how to modify a previously submitted PDE.

2. Objective

The information contained within this module applies to benefit years 2025 and forward. For benefit years prior to 2025, refer to the [2011 PDE Participant Guide](#) located on the Customer Service and Support Center (CSSC) website.

The information provided in this module will:

- Explain the processes required for data submission.
- Describe the PDE file layout logic.
- Identify the fields and functions in the PDE record format.
- Define standard and non-standard data collection formats.
- Identify the PDE fields added to implement provisions in the Inflation Reduction Act (IRA) and to improve CMS' ability to evaluate data quality.
- Explain how to modify a PDE record.

3. Requirements for Submitting a Prescription Drug Event Record

The PDE record contains prescription drug cost and payment data that enable CMS to reconcile payments to plans on an annual basis and otherwise administer the Part D benefit. Specifically, the PDE record includes covered drug costs above and below the Out-of-Pocket (OOP) threshold; amounts attributable to manufacturer discounts; distinguishes enhanced alternative costs from the costs of drugs provided under the Basic benefit; and records payments made by Part D sponsors, other payers, beneficiaries, or individuals on behalf of a beneficiary. Plans must also identify costs that contribute toward a beneficiary's True Out-of-Pocket (TrOOP) limit. Several new fields were added to the PDE record to support the provisions in the IRA, including the Manufacturer Discount Program (MDP), the Selected Drug Subsidy Program, the Medicare Prescription Payment Plan, and the Drug Price Negotiation Program and the requirement to conform with regulatory provisions and oversight activities, including the regulatory requirement to account for the maximum pharmacy price concession in the negotiated price.

Many electronic transactions take place between plans, pharmacies, and intermediaries when an enrollee fills a prescription. This process allows determination of patient cost-sharing at the point of sale (POS) by plan adjudication of the claim and drives eventual plan payment to the pharmacy.

The PDE record is a summary of a dispensing event that contains information derived from these multiple transactions associated with the prescription, as well as additional CMS defined information. CMS expects that the plan will be able to directly link any PDE to the individual claim transactions from which the PDE was extracted and will conduct audits of PDE data to ensure the accuracy of payment.

Prior to submitting production data, plans must understand the components of the submission enrollment package, connectivity options, testing, and the submission timeline.

3.1 Electronic Data Interchange Onboarding

There are four documents relevant to onboarding: the Electronic Data Interchange (EDI) Agreement, the Submitter/Receiver ID Application, the Submitter Authorization Form and the Connect:Direct Form (if applicable). Part D sponsors may submit their own data or authorize a third-party to submit PDEs on their behalf. Regardless of which entity submits PDE data on behalf of the Part D sponsor, all parties must complete the [EDI Onboarding Forms](#) located on the CSSC Operations website.

Table 1: Data Submission Documentation Requirements

Form	Entity	Description
EDI Agreement	All eligible organizations including plans and third-party submitters	<ul style="list-style-type: none"> The EDI Agreement is used by organizations wishing to exchange data files with the Customer Service Front End System (CSFES). This agreement needs to be completed and signed by an authorized agent of the organization.
Submitter/Receiver ID Application	All eligible organizations including plans and third-party submitters	<ul style="list-style-type: none"> The Submitter/Receiver ID Application is used when an organization needs to obtain a Submitter or Receiver ID to exchange data with the CSFES.
Submitter Authorization Form	Plans who wish to designate a third-party submitter	<ul style="list-style-type: none"> The Submitter Authorization Form is intended to provide notification to CSSC Operations when an organization will submit and receive data on behalf of a plan.
Connect:Direct Form	Organizations utilizing Connect:Direct	<ul style="list-style-type: none"> The Connect:Direct Form provides the parameters CSSC Operations has defined that organizations will need to use when exchanging data files using the Connect:Direct software. Organizations need to complete this form to provide unique dataset names for return report delivery.

Upon successful completion of all onboarding documents, a Submitter ID and Test Contract ID will be assigned to the submitter. Anyone who submits data (the plan itself or a third-party) must complete testing and certification. CSSC Operations must be notified of any changes that could impact the exchange of PDE data.

3.2 Connectivity

All organizations that exchange PDE data can elect to establish connectivity directly to CMS by contacting the [Medicare Advantage Prescription Drug \(MAPD\) Help Desk](#) or establish a secure connection through a CMS-approved Network Service Vendor (NSV).

Connectivity refers to the electronic connection used to submit PDE records and receive reports from CMS. Technical specifications are available based on the communication medium that the organization intends to use. The [Medicare Advantage and Part D Communications Handbook](#) is available on the CSSC Operations website on the EDI Onboarding and Connectivity page. The

three connectivity options, and the response time associated with each, are described in Table 2.

Table 2: Connectivity Options

Connect:Direct	File Transfer Protocol (FTP)	CMS Enterprise File Transfer (Gentran)
<ul style="list-style-type: none"> Mainframe-to-mainframe connection. Same day receipt of front-end response if file is received before 1:00pm ET. Next day receipt if file is received after 1:00pm ET. 	<ul style="list-style-type: none"> Secure FTP. Same day receipt of front-end response. 	<ul style="list-style-type: none"> Secure FTP. Same day receipt of front-end response if file is received before 1:00pm ET. Next day receipt if file is received after 1:00pm ET.

Small plans with less than or equal to 100,000 enrollees may submit data using the Gentran Mailbox. For technical support questions regarding Gentran, users may contact the MAPD Help Desk by calling (800) 927-8069, emailing MAPDHELP@cms.hhs.gov, or accessing the [MAPD Help Desk](#) website.

Note: Datasets must be set up for Connect:Direct users. The Prescription Drug Data specifications should be completed and returned to the CSSC with the Submitter/Receiver ID Application and the EDI Agreement using the EDI Onboarding Forms tool. Connect:Direct specifications are available in the Medicare Advantage and Part D Communications [Handbook](#) located on the CSSC Operations website.

3.3 Prescription Drug Event Certification Process

Prior to submitting production files, all submitters must complete testing and certification. All new submitters or submitters not previously certified must complete the initial certification process. CSSC coordinates the certification process; procedures are published on the [EDI Onboarding and Connectivity](#) page on the CSSC Operations website.

Re-certification is generally not required every year for existing submitters. On limited occasions where the PDE record format, file format, or submission process undergoes significant changes, CMS will require all submitters or plans to re-certify. Plans will be notified in advance if a program-wide re-certification effort is mandatory.

Testing and certification include two levels of editing. The submitter achieves certification only after successful completion of all requirements.

1. Prescription Drug Front-End System (PDFS) Phase: Submitters must establish connectivity with PDFS, transmit successfully, and clear PDFS edits.
2. Drug Data Processing System (DDPS) Phase: Submitters must achieve the required acceptance rate, submit the required number of records, and they must include all required test cases as described in the annual PDE Test Certification Package.

PDE test data must be submitted from the same automated system that will be used to submit production data.

CSSC will notify submitters when they have met certification requirements. Once certified, submitters may submit production files.

3.4 Data Submission Timeline

Submitters must submit PDE records electronically to the PDFS according to the schedule in Table 3.

Table 3: The Annual PDE Data Submission Timeline

Data Type	Submission Timeline
Testing and Certification*	November 15 – January 31
Production Submissions**	Monthly, March 31 – June 30***

*For calendar year 2025, all Part D submitters must complete the certification process. For calendar years starting in 2026, only new plans submitting directly, or new third-party submitters must complete the testing and certification process.

**Existing plans must submit at least one accepted PDE file per calendar month beginning in January of each benefit year. New plans must submit at least one accepted PDE file prior to March 31. All plans must comply with the routine production submission schedule listed in the Annual PDE Data Submission Timeline.

***Original PDE records, adjustments, or deletions that are received after the last Federal business day prior to June 30th of the subsequent coverage year are not considered in annual Part D Payment Reconciliation.

3.4.1 Plan Monitoring

Throughout the coverage year, CMS monitors plan data submission levels to detect plans with submission volumes lower than expected. Low submission patterns often indicate technical or system problems. CMS works with plans to correct submission problems before the end of the year so they can meet reconciliation submission deadlines. However, it is the responsibility of the plan to submit adequate data for payment.

Specifically, CMS monitors the following:

- **Submission Timeliness:** Plans must submit at least one successful PDE file per month. There is an established compliance procedure for plans who do not meet this requirement.
- **Submission Completeness:** CMS monitors the extent to which PDE submission volume follows plan or program-wide historical trends.
- **Submission Lag:** CMS expects PDEs to be submitted within 30 days of the date of service (DOS). Rejected records should be corrected and resubmitted within 90 days unless the plan realizes that the PDE should not have been submitted at all. Adjustment/Deletion PDEs should be submitted within 90 days of the event that changed the original PDE.

4. Data Collection

For each dispensing event, the plan must submit a PDE record. Many organizations use a Pharmacy Benefit Manager (PBM) or other third-party administrator to process incoming claims from pharmacies. Claims typically undergo several rounds of transactions between these parties before the plan finally adjudicates a claim for payment. The PDE is a summary record that documents the final adjudication of a dispensing event.

Reminder: A plan maintains ultimate responsibility for the accuracy of PDE data submitted to CMS independent of whether the data is self-submitted or submitted by a third-party (e.g., PBM) on the plan's behalf. Plans have an additional reporting requirement to submit Direct and Indirect Remuneration (DIR) data for year-end reconciliation. PDE reporting and DIR reporting are separate information streams. Each year, CMS publishes a Health Plan Management System (HPMS) memorandum titled *Medicare Part D DIR Reporting Guidance* detailing specific requirements for reporting DIR, which plans should reference for additional information.

5. Prescription Drug Event Record Layout Logic

The PDE record is organized into three levels:

- File level information, which identifies the submitter.
- Batch level information, which identifies the contract / Plan Benefit Package (PBP).
- Detail level information, which identifies the beneficiary and describes the prescription drug event.

A summary of the PDE Inbound File layout is illustrated in Figure 1 and the PDE Outbound File is illustrated in Figure 2. A detailed description of each field, including formatting requirements, is on the [File and Report Layouts](#) page on the CSSC Operations website. (The record length of all records (file level, batch level, and detail level) is 1000 bytes.

Note: The National Council for Prescription Drug Programs (NCPDP) uses the character coding scheme known as the Extended Binary Coded Decimal Interchange Code (EBCDIC). Because PDEs comply with the NCPDP format, PDEs must be submitted in EBCDIC. If data is compiled in an alternate coding scheme like the American Standard Code for Information Interchange (ASCII), the data must be converted to EBCDIC. Because DDPS uses the EBCDIC coding scheme, the system will not correctly interpret data submitted in the ASCII format. For example, EBCDIC represents signed numeric fields differently from ASCII. The last position of the signed field expresses both the numeric value and its sign. In EBCDIC, an "A" in the last position indicates that the last digit is 1 and the field is positive, a "J" in the last position indicates that the last digit is 1 and the field is negative. ASCII, on the other hand, interprets "A" as a character. Programs that convert from ASCII to EBCDIC are available from commercial vendors. The only requirements for these Commercial Off-the-Shelf (COTS) tools are that the input ASCII layout contains all the necessary data needed to correctly convert the file to the appropriate EBCDIC layout.

Figure 1: Inbound PDE Record File Structure Summary

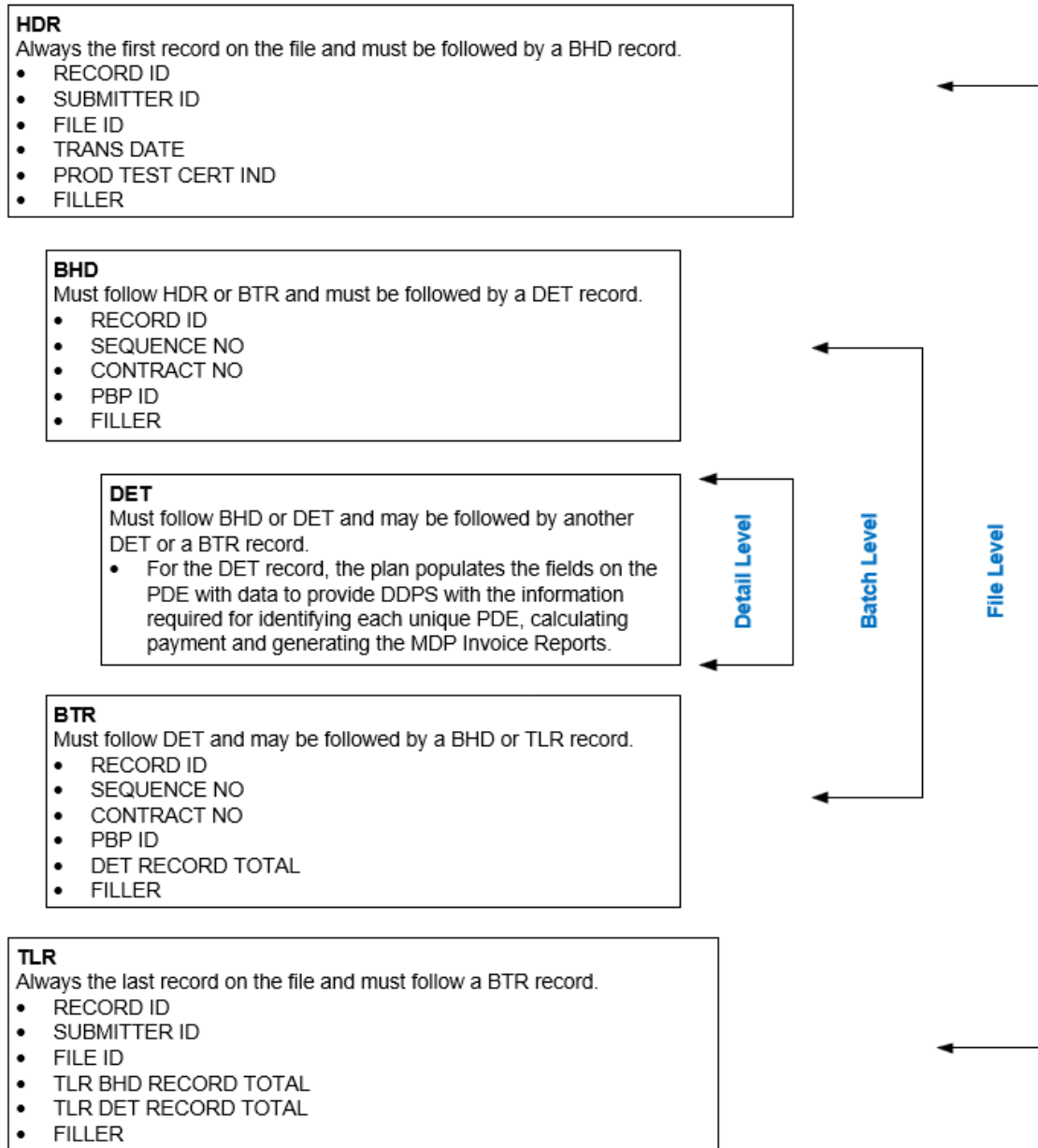
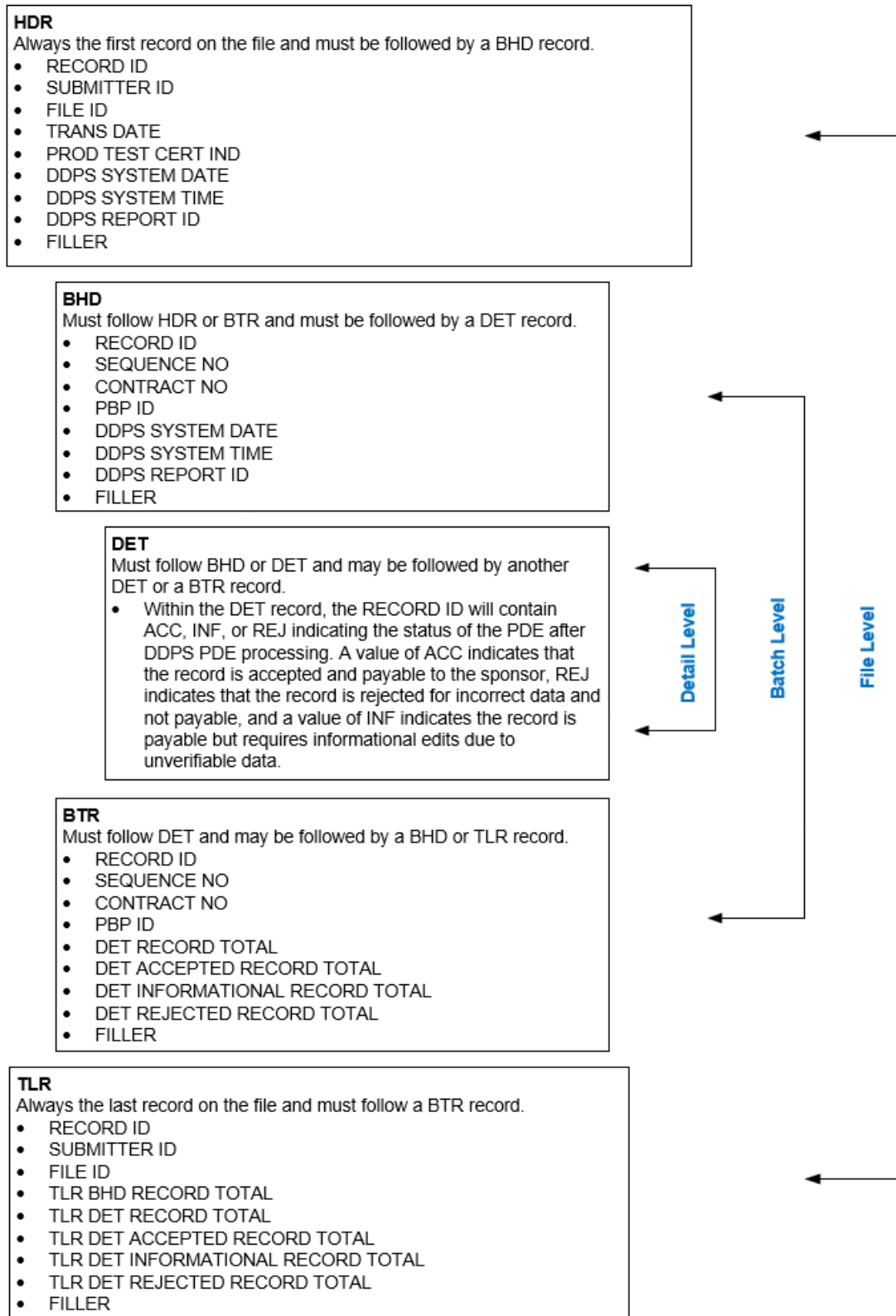


Figure 2: Outbound PDE Record File Structure Summary



5.1 File Level Fields

The file level of the PDE record consists of a file header (HDR) and a file trailer (TLR). These are the first and last records in the PDE file. Each record is 1000 bytes. The naming conventions HDR and TLR are used to populate the Record ID fields at the file level.

The file header contains four fields that are used for processing and tracking submissions. Table 4 provides an overview of those fields.

Table 4: File-level Information

Field Name	Characteristics
SUBMITTER ID	<ul style="list-style-type: none"> Assigned by CMS (CSSC). Identifies the entity that is submitting the data. Must be accurate for appropriate routing of reports and return files.
FILE ID	<ul style="list-style-type: none"> Assigned by submitter for file identification purposes. The same number can only be used once in a 12-month period. Ten-character alphanumeric field.
TRANS DATE	<ul style="list-style-type: none"> The date on which the file is transmitted to PDFS/DDPS. CCYYMMDD format.
PROD TEST CERT IND	<ul style="list-style-type: none"> Indicates if the file is being submitted as a prod, test, or cert file. Production data are stored separately from test and cert data. <ul style="list-style-type: none"> PROD indicates that the file is a production file. TEST indicates that the file is a test file in the 512-byte format. CERT indicates that the file is submitted to earn certification status in the 512-byte format. TS1K indicates that the file is a test file in the 1000-byte format. CT1K indicates that the file is submitted to earn certification status in the 1000-byte format.

HDR fields 2 and 3, Submitter ID and File ID, are repeated in the TLR fields 2 and 3. The remaining TLR fields confirm input batch and DET record counts.

5.2 Batch Level Fields

Like the HDR and TLR, each batch record within the PDE record equals 1000 bytes. There can be multiple batches within a file, but each must have a batch header and trailer. The batch header is a BHD record, and the trailer is a BTR record; these naming conventions are used to populate the Record ID fields at the batch level.

Batch level information that identifies the plan is reported in two fields: Contract No and PBP ID. CMS assigns the Contract No, while the organization proposes PBP IDs when bidding. Each bid must be approved by CMS during the negotiation and contracting process. The Contract No consists of a letter followed by four numbers. The initial letter will vary by plan type as outlined in Table 5.

Table 5: Contract Number Enumeration by Plan Type

Plan Type	First Letter Enumeration
Local Medicare Advantage Prescription Drug (MA-PD) Plans	<ul style="list-style-type: none"> Begins with an 'H' <ul style="list-style-type: none"> e.g., H1234
Regional MA-PD Plans	Begins with an 'R'
Prescription Drug Plans (PDP)	Begins with an 'S'
LI NET Contract	Begins with an 'X'

Plan Type	First Letter Enumeration
Directly Contracted Employer Group Waiver Plans (EGWP)	Begins with an 'E'

The Contract No is used in conjunction with the PBP ID to describe the organization and the plan for which the data are being submitted. This requires that all DET records included between a set of batch level records (i.e., a BHD and BTR record) are for beneficiaries enrolled in both the contract and the PBP identified at the batch level by the Contract No and PBP ID fields. Contracts submitting records for multiple PBPs must separate data at the batch level.

Batch level data also provides information necessary for tracking. The Batch Sequence No is entered by the submitter and identifies the order in which batches were submitted within the file. Instructions for populating this field are outlined in Table 6.

Table 6: Sequence Number Characteristics

Field Name	Characteristics
SEQUENCE NO	<ul style="list-style-type: none"> Assigned by submitter. Must begin with 0000001 and increment by 1.

BHD fields 2 through 4, Sequence No, Contract No, and PBP ID are repeated in the BTR fields 2 through 4. The remaining BTR field confirms input record counts.

5.3 Detail Level Fields

The DET record includes data elements that plans must populate for CMS to reconcile payment, provide program oversight, and populate the MDP Invoice Reports. Plans must sort DET records within each batch by the Medicare Beneficiary Identifier (MBI). This section reviews data elements within the DET record, with emphasis on data used for payment reconciliation and for provisions in the IRA.

Every DET record will contain the Record ID, populated with DET as well as the Sequence No. This field must begin with 0000001 and increment by 1.

5.3.1 Entity Identification

In addition to the Submitter ID, Contract No and PBP ID found on the batch (BHD) level record, a detail record also has a Record ID and Sequence No. On the DDPS Inbound File, the Record ID will be DET to indicate detail records. On the DDPS Return File, the Record ID field will contain ACC, REJ, or INF. A value of ACC indicates that the record is accepted and payable to the sponsor, REJ indicates that the record is rejected for incorrect data and not payable, and a value of INF indicates the record is payable but requires informational edits due to unverifiable data. On both the DDPS Inbound File and DDPS Return File, the Sequence No starts with 0000001 and increases sequentially within a batch header and trailer record.

5.3.2 Beneficiary Information

The following data elements identify the beneficiary:

- Medicare Beneficiary Identifier – Indicates the Medicare beneficiary’s identification number that is assigned by CMS. Railroad Retirement Board (RRB) numbers issued before 1964 are 6-digit numbers preceded with an alpha prefix. After 1964 the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix.

- Cardholder ID – Indicates the number assigned to the beneficiary by the plan. Plans map MBIs to the Cardholder ID so they can link to internal databases.
- Patient Date of Birth (DOB) – Indicates the beneficiary’s date of birth. This is an optional field, but if reported, must be valid.
- Patient Gender Code – Indicates the beneficiary’s gender and is used to validate the identity of the beneficiary.
- Patient Residence – Indicates where the beneficiary lived (e.g., home, nursing facility, assisted living facility, hospice, etc.) when the prescription was filled.

Reminders:

- All data in the DET record must be for beneficiaries enrolled in the contract and PBP indicated at the batch level.
- DET records within batches must be sorted by MBI.

5.3.3 Event Identification Information

The data elements in this section assist in identifying the prescription drug event.

- Claim Control Number – Identifies a number assigned by the plan to identify the prescription drug event. This is an optional field.
- Date of Service (DOS) – Identifies the date on which the prescription was filled.
- Paid Date – Identifies the date when payment was made from the plan or PBM to the pharmacy, not the date the claim was processed and agreed to be paid. It is required only for fallback prescription drug plans and is optional for all other plan types.
- Prescription Service Reference No – Identifies the prescription reference number assigned by the pharmacy at the time the prescription was filled.
- Fill Number – Identifies the fill number of the current dispensed supply.
- Dispense as Written (DAW) Product Selection Code – Identifies the prescriber's instruction regarding substitution of generic equivalents when dispensing the specific prescribed medication.
- Adjustment Deletion Code – Identifies if the PDE is an original claim, an adjustment claim, or a deletion claim.
- Non-Standard Format Code – Identifies the type of source data the plan used to compile the PDE. This includes Medicaid subrogation claim, beneficiary submitted claim, Coordination of Benefits (COB) claim, paper claim, X12 837, or NCPDP electronic format.
- Pricing Exception Code – Identifies PDEs using pricing rules that differ from the plan’s negotiated price. This includes Medicare as secondary payer and an out-of-network pharmacy.
- Medicare Prescription Payment Plan Indicator – Identifies if the beneficiary is participating in the Medicare Prescription Payment Plan for the claim submitted.
- Prescription Origin Code – Identifies the method in which the pharmacy received the prescription (e.g., written, telephone, electronic, etc.).
- Date Original Claim Received – Identifies the date when the plan received the original claim. The date does not change when a corrected PDE is submitted to document a claim correction. This field is used to identify claims with processing lags and to reconcile LI NET plans.

- Claim Adjudication Began Timestamp – Identifies the date and time that the sponsor began adjudicating the claim in Greenwich Mean Time.
- Submission Type Code (1-5) – Used to identify specific types of claims including 340B claims, split billing, nominal price, synchronization fill, or trial fill PDEs.
- Submission Clarification Code (1-5) – Indicates how many days' supply of the medication was dispensed by the long-term care pharmacy for beneficiaries living in long-term care (LTC) facilities.
- LTPAC Dispense Frequency – Indicates the dispense frequency for long-term and post-acute care short-cycle (LTPAC) dispensing.
- Adjustment Reason Code Qualifier – Indicates the type of Adjustment Reason Code used in the Adjustment Reason Code field (e.g., CMS audit, CMS identified overpayment, etc.).
- Adjustment Reason Code – Indicates the reason for an adjustment or deletion and is dependent on the value submitted in the Adjustment Reason Code Qualifier.

5.3.4 Drug and Quantity Identification

The data elements in this section assist in identifying the drug and quantity of the prescription drug event.

- Product Service ID – Identifies the dispensed drug product using a National Drug Code (NDC).
- Compound Code – Indicates whether the dispensed drug was compounded or mixed.
- Quantity Prescribed – Indicates the original quantity prescribed for Schedule II drugs that are reported on standard, electronically-submitted PDEs.
- Quantity Dispensed – Indicates the number of Units, Grams, Milliliters, other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed; report quantity in the unit form of the final state of the resulting compound.
- Days Supply – Indicates the number of days' supply of medication dispensed by the pharmacy.

5.3.5 Cost Information

The data elements in this section assist in identifying the costs of the drug. Plans must report the dollar amounts paid to the pharmacy.

- Ingredient Cost Paid – Indicates the amount the plan paid the pharmacy for the drug itself.
- Dispensing Fee Paid – Indicates the amount the plan paid the pharmacy for dispensing the medication.
- Total Amount Attributed to Sales Tax – Indicates the amount the plan paid the pharmacy to cover sales tax.
- Vaccine Administration Fee or Additional Dispensing Fee – Indicates the net amount the plan paid the pharmacy for administering a vaccination. This field may also include amounts of additional dispensing fees paid for oral antiviral drugs procured by the U.S. Government, over and above what was reported in the "Dispensing Fee Paid" field.

5.3.6 Payment Breakout Information

The data elements in this section assist in identifying the patient liability payments, plan payments, and benefit accumulators.

- Catastrophic Coverage Code – Optional field that indicates if the attachment point was met on the PDE, if the PDE was above the attachment point, or if the attachment point was not met. EGWPs can also use this field to indicate if the attachment point was met, but the TrOOP was subsequently reduced below the OOP threshold due to payment amounts from non-EGWP other payers reported in the Patient Liability Reduction Due to Other Payer Amount (PLRO) field.
- Estimated Remuneration at POS Amount (ERPOSA) – Indicates the amount of remuneration the plan applied to reduce the negotiated price made available to the beneficiary.
- Pharmacy Price Concessions at POS – Indicates the maximum amount of pharmacy price concessions the plan applied to reduce the negotiated price made available to the beneficiary.
- Gross Drug Cost Below Out-of-Pocket Threshold (GDCB) – Indicates the amount of covered drug costs below the OOP threshold.
- Gross Drug Cost Above Out-of-Pocket Threshold (GDCA) – Indicates the amount of covered drug costs above the OOP threshold.
- Patient Pay Amount – Indicates the amount of beneficiary liability.
- Other TrOOP Amount – Indicates the amount contributed by other qualified parties that are TrOOP-eligible, such as State Pharmaceutical Assistance Programs (SPAPs) or charities.
- Low-Income Cost-Sharing Subsidy Amount (LICS) – Indicates the amount the plan advanced at POS due to a beneficiary's LI status.
- Patient Liability Reduction Due to Other Payer Amount (PLRO) – Indicates the amount of beneficiary liability contributed by other non-qualified parties that are not TrOOP-eligible.
- Covered D Plan Paid Amount (CPP) – Indicates the net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit.
- Non-covered Plan Paid Amount (NPP) – Indicates the amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs) or the non-Part D supplemental payment reported by EGWPs on or after 1/1/2025.
- Selected Drug Subsidy – Indicates the reported subsidy amount that the plan advanced at the POS for a selected drug in the Initial Coverage Period.
- Reported Manufacturer Discount – Indicates the discount amount from the Manufacturer Discount Program (MDP) for applicable drugs.
- Reported Gap Discount – Indicates the discount amount from the Coverage Gap Discount Program for applicable drugs. Beginning in 2025, this field must be equal to \$0.
- Total Gross Covered Drug Cost Accumulator – Indicates the sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim.
- True Out-of-Pocket (TrOOP) Accumulator – Indicates the sum of beneficiary's incurred costs for the benefit year known immediately prior to adjudicating the claim.
- Other TrOOP Amount Indicator – Indicates when the Other TrOOP Amount field includes Inflation Reduction Act Subsidy Amount (IRASA) dollars for benefit year 2023.

5.3.7 Prescriber Information

The data elements in this section assist in identifying the prescriber of the prescription drug event.

- Prescriber ID Qualifier – Indicates the type of prescriber identification number submitted on the PDE. This field may only be populated with a National Provider Identifier (NPI).
- Prescriber ID – Identifies the individual who prescribed the medication. This field may only be populated with an NPI.

5.3.8 Service Provider Information

The data elements in this section assist in identifying the service provider who dispensed the prescription.

- Service Provider ID Qualifier – Indicates the type of ID being submitted in the Service Provider ID field (NPI, UPIN, NCPDP Provider ID, State License, Federal Tax Number, or Other).
- Service Provider ID – Identifies the provider (e.g., pharmacy) who dispensed the prescription.
- Pharmacy Service Type – Indicates the type of pharmacy that dispensed the prescription.

5.3.9 Benefit Design Information

The data elements in this section assist in identifying the benefit design under which the prescription drug event was adjudicated.

- Drug Coverage Status Code – Indicates the status of the dispensed drug as covered (a Part D drug that has been approved for coverage under a specific PBP), enhanced (not a Part D drug, but approved for coverage under a specific PBP), or Over-the-Counter (OTC) (used as part of the PBP's utilization management program and approved for coverage under a specific PBP).
- Part D Model Indicator – Indicates the type of Part D Model applied to the PDE for a beneficiary enrolled in a plan with a Part D Model.
- Beginning Benefit Phase – Indicates the plan-defined phase that is in effect for the beneficiary at the time the plan begins adjudication of the claim being reported. This field is reported for covered drugs only.
- Ending Benefit Phase – Indicates the plan-defined phase that is in effect for the beneficiary at the time the plan completes adjudication of the claim being reported. This field is reported for covered drugs only.
- Brand/Generic Code – Indicates that the plan adjudicated the claim as a brand drug or as a generic drug.
- Tier – Indicates the formulary tier (consistent with the plan's benefit as submitted to CMS in the formulary file) in which the sponsor adjudicated the claim. Defined Standard benefit plans and plans with an open formulary and no tiering should report the default value of '1' in the Tier field. When a prescription for a non-formulary drug is approved under an exception process and adjudicated with tier cost-sharing, report the exception tier.

- **Formulary Code** – Indicates if the drug is on a plan’s formulary. This field applies to covered drugs only. Defined Standard plans covering all Part D drugs should report ‘F’ in the Formulary Code field. For plans with a closed formulary, if a drug is covered through an exception or appeal and was not originally on the plan’s formulary as submitted to CMS, report ‘N’ in the Formulary Code field.

5.3.10 Fields Returned by DDPS

The data elements in this section are returned on the prescription drug event after processing. All fields listed are part of the filler field on the PDE Inbound File and will be populated by the plans with spaces.

- **CMS Calculated Gap Discount** – DDPS will populate as applicable based on editing. For PDEs with a DOS \geq 01/01/2011 and a DOS \leq 12/31/2024, this field will contain the Gap Discount Amount calculated by CMS during on-line PDE editing based on data reported on the PDE.
- **CMS Calculated Manufacturer Discount** – DDPS will populate as applicable based on editing. This field contains the Manufacturer Discount Amount calculated by CMS during on-line PDE editing based on data reported on the PDE.
- **Applicable Discount Percentage for Specified Small Manufacturer Drugs** – DDPS will populate as applicable based on editing. This field contains the phased-in Manufacturer Discount percentage that applies for the benefit year of the PDE for specified small manufacturer drugs dispensed to beneficiaries, as provided by the statute.
- **Applicable Discount Percentage for Specified Manufacturer Drugs Dispensed to LIS Beneficiaries** – DDPS will populate as applicable based on editing. This field contains the phased-in Manufacturer Discount percentage that applies for the benefit year of the PDE for specified manufacturer drugs dispensed to Low-Income Subsidy (LIS) eligible beneficiaries, as provided by the statute.
- **Drug Status Indicator** – DDPS will populate as applicable based on editing. This field contains the corresponding value identifying whether the NDC was considered an applicable drug, non-applicable drug, or selected drug by DDPS at the time of PDE processing for purposes of Manufacturer Discount / selected drug applicability and reinsurance calculations.
- **Alternate Service Provider ID Qualifier** – DDPS will populate as applicable based on editing. This field contains the Alternate Service Provider ID Qualifier cross-referenced by CMS to the Service Provider ID submitted on the PDE.
- **Alternate Service Provider ID** – DDPS will populate as applicable based on editing. This field contains the Alternate Service Provider ID cross-referenced by CMS to the Service Provider ID submitted on the PDE.
- **Original Submitting Contract** – DDPS will populate as applicable based on editing. This field contains the Contract that submitted the previously accepted PDE (in conjunction with Edit 784).
- **Corrected Medicare Beneficiary Identifier** – DDPS will populate as applicable based on editing. This field contains the MBI if the Health Insurance Claim Number (HICN) was received on the PDE submission file or the beneficiary MBI has changed according to CMS records.
- **P2P Contract of Record** - Contract of Record for accepted Plan-to-Plan (P2P) PDEs.

- PBP of Record –This field contains the PBP of Record assigned by CMS during the P2P Update Process and is returned only when the PBP of Record changes from the time the PDE was processed and accepted by CMS.
- Error Count – DDPS will populate as applicable based on editing. This field contains the count of errors encountered during processing.
- Error fields (1-10) – DDPS will populate as applicable based on editing. These fields contain the count of errors encountered during PDE processing as well as the edits received.
- Exclusion Reason Code – DDPS will populate as applicable based on editing. This field contains the subcategory reject code for an NDC Error Code of 738 identified in Errors 1-10.

6. Non-Standard Format

It is expected that most data that plans collect from providers will be in standard format (i.e., NCPDP electronic format). However, plans may receive data in other formats. Independent of the type of source data from which the PDE is compiled, plans must submit PDEs for all events. The Non-Standard Format Code reports the type of source data from which the PDE was compiled. Table 7 lists the values for the Non-Standard Format Code field. Note that these codes are mutually exclusive.

Table 7: Non-standard Format Field Codes

Data Source	Code
Medicaid subrogation claim	A
Beneficiary submitted claim	B
COB claim	C
Paper claim from provider	P
X12 837 format	X
NCPDP electronic format	<SPACE>

When PDEs are compiled from NCPDP electronic format, the non-standard format field is populated with a space. Non-Standard Format Code values of 'A', 'B', 'C', 'P', or 'X' indicate that the PDE record was derived from a non-standard format.

CMS expects plans and their PBMs to implement standard protocols for non-standard format claims. Documentation to substantiate a non-standard format claim should almost always be equivalent to data required for PDEs derived from NCPDP electronic format claims. Although current CMS guidance allows some flexibility when submitting non-standard format PDEs, plans should use discretion and report default values only when necessary. Plans should report the NPIs for prescribers. Since May 2008 when NPI reporting was fully implemented, prescriber NPIs should be readily available. CMS will validate NPIs when the Prescriber ID Qualifier value indicates that the data in the Prescriber ID is an NPI. Currently CMS retains the flexibility to report a plan-defined value in the Prescriber ID field. Since the option to report default values for prescribers is limited to emergency circumstances, plans who continue to use default prescriber values routinely can expect additional scrutiny both from CMS and their auditors. Non-standard format PDEs may report default values as specified for fields listed within Table 8.

For these fields, plans may report default values when data are unavailable. For example, the Prescription Service Reference No is typically assigned by a pharmacy at the time a prescription is filled. However, if the drug is dispensed in a physician's office, this number may not be

included on the claim so the plan will have to assign a number that is unique for the DOS and the service provider. Table 8 provides the field name and the default value or instructions directing plans to populate these fields when source data are not available.

Table 8: Instructions for Populating the Non-standard Format PDE Record (For limited use only)

Field Name	Instructions
Prescription Service Reference No	Assign a number that will be unique for the DOS and the service provider.
Service Provider ID	Utilize the UPIN, NCPDP Provider ID, State License, Federal Tax Number or the default value of "PAPERCLAIM" if an NPI is not available.
Fill Number	Populate with: '00'
Compound Code	Populate with: '0' (not specified)
Dispense as Written (DAW) Product Selection Code	Populate with: '0' (no product selection indicated)
Days Supply	Populate with: '000'
Prescriber ID	Populate with plan defined value.

Reminder: Plans are under the same obligation to maintain an audit trail and submit accurate data independent of the data source.

7. Modifying Prescription Drug Event Records

To change a PDE after DDPS saves it, plans will submit an adjustment or deletion PDE. A small number of systems use "void and replace" methodology instead of adjustment logic. These systems do not send adjustment PDEs. They change data by voiding the record in error and replacing it with a new record.

DDPS accepts either adjustments or "void and replace" changes. We use the term adjustment to describe both methods to change data. Examples of when an adjustment or deletion might be required include:

- Deletion: A beneficiary does not pick up a prescription, and the plan is not notified until after the PDE record has been accepted.
- Adjustment: The pharmacy receives an Other Health Insurance (OHI) payment after the PDE has been accepted.
- Adjustment: A beneficiary is declared eligible for low-income assistance and the benefits are retroactive across several PDEs that have been accepted.
- Adjustment: The original payment to the pharmacy is changed after DDPS accepted the PDE.
- Resubmission: A new PDE containing the same key fields as a previously deleted PDE is submitted, but the Patient Pay Amount field differs from the previously deleted PDE.

When the Adjustment Deletion Code is populated, DDPS recognizes that a record is being either adjusted or deleted. For one of these actions to take place, the record submitted with the Adjustment Deletion Code populated must match the record in the database to be adjusted or deleted in the following eight fields.

- MBI
- Service Provider ID

- Service Provider ID Qualifier
- Prescription Service Reference No
- DOS
- Fill Number
- Contract No
- PBP ID

The first six fields are in the DET record. The MBI is used to assist DDPS with ensuring the correct PDE is being adjusted or deleted. The last two fields, located in the BHD, identify the contract number of the plan that originally submitted the PDE record and the Plan Benefit Package to which the beneficiary belongs. DDPS includes Contract No and PBP ID in adjustment match logic to reserve adjustment and deletion authority to the plan that originally submitted the data.

Table 9 provides an overview of the impact of each code.

Table 9: Impact of the Adjustment/Deletion Code on PDE Records

Code	Code Definition	Impact
A	Adjustment	If the adjustment PDE record, matching the eight fields, is found in the DDPS database, the system will save the adjustment record.
D	Deletion	If the deletion PDE record, matching the eight fields, is found in the DDPS database, the system will save the deletion record.
<SPACE>	Original	Indicates original or a resubmission.

If a current PDE record that satisfies the matching logic is not found, DDPS rejects the adjustment or deletion record and returns an edit code and associated error message.

There are several things to keep in mind when undertaking this process:

- Adjustment and deletion PDEs should not be included within the same submitter file (BHD/BTR) as the original record. Until the original PDE has been processed by DDPS, any adjustment and/or deletion would not be accepted.
- Deletion PDE records (i.e., previously submitted records) are excluded from any payment calculations.
- Deletion PDE records cannot be adjusted. If a plan wants to adjust a record that has previously been deleted, a new original record must be submitted. A record that has previously been adjusted but not deleted can be adjusted again.

Reminder: CMS uses the term “final action” to describe the most recently accepted original, adjustment, or delete PDE record representing a single dispensing event.

Plans can minimize adjustment/deletion volume by waiting to submit PDEs until data have been finalized; however, plans must submit data according to the timeline specified by CMS, which is at least one accepted PDE file per calendar month and a PDE submission lag time of original PDEs submitted within 30 days of the date the claim was received.

Appendix A: Acronyms

Table 10: Acronyms

Acronym	Literal Translation
ASCII	American Standard Code for Information Interchange
CMS	Centers for Medicare & Medicaid Services
COTS	Commercial Off-the-Shelf
CPP	Covered D Plan Paid Amount
CSSC	Customer Service and Support Center
DAW	Dispense as Written
DDPS	Drug Data Processing System
DEA	Drug Enforcement Agency
DIR	Direct and Indirect Remuneration
DOB	Date of Birth
EBCDIC	Extended Binary Coded Decimal Interchange Code
EDI	Electronic Data Interchange
EGWP	Employer Group Waiver Plan
ERPOSA	Estimated Remuneration at POS Amount
FTP	File Transfer Protocol
GDCA	Gross Drug Cost Above Out-Of-Pocket Threshold
GDCB	Gross Drug Cost Below Out-Of-Pocket Threshold
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HRI	Health Related Item
IRA	Inflation Reduction Act
LICS	Low-Income Cost-Sharing Subsidy Amount
LIS	Low-Income Subsidy
MA-PD	Medicare Advantage Prescription Drug Plan
MDP	Manufacturer Discount Program
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NPP	Non-Covered Plan Paid Amount
OHI	Other Health Insurance
OOP	Out-of-Pocket
OTC	Over-the-Counter
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDE	Prescription Drug Event
PDFS	Prescription Drug Front-End System

Acronym	Literal Translation
PDP	Prescription Drug Plan
PLRO	Patient Liability Reduction due to Other Payer Amount
POS	Point of Sale
RRB	Railroad Retirement Board
SPAP	State Pharmaceutical Assistance Program
TrOOP	True Out-of-Pocket Costs
UPIN	Unique Physician Identification Number
UPN	Universal Product Number