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Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process

This document provides an overview of the processes and entities involved in the coordination of benefits for Medicare Part D beneficiaries, and provides recommendations for industry-standard practices.

July 2013

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NCPDP Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process

Version 1.0

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Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.0 July 2013
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The task group members, white paper authors, and other contributors of this paper will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

1. PURPOSE

NCPDP has created this overview as guidance intended for all parties involved in managing Part D benefits for Medicare beneficiaries. These parties include, but are not limited to, State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs (ADAPs), Part D Sponsors, Pharmacy Software Vendors, Pharmacy Switches, Prescription Benefit Managers (PBMs), Medicaid Agencies, Payers offering a supplemental benefit to Medicare beneficiaries, Providers that dispense medications to Medicare eligible beneficiaries, and Contractors (Transaction Facilitator, COB contractors, etc.) that support coordination of Medicare Part D benefits.

This white paper is intended to provide a consolidated overview of the transactions required to properly coordinate benefits and track True Out Of Pocket (TrOOP) dollars or other out of pocket expenditures when a supplemental payer contributes to the beneficiary's portion of the cost sharing remaining on a Medicare Part D claim.

NCPDP WG1 Information Reporting Problems Task Group worked with the Centers for Medicare and Medicaid Services (CMS) and a variety of industry partners to review the entire COB process. During this discussion, the group identified issues and developed suggestions the reader may find useful to understand this electronic process. The reader will note this paper is organized to first define key terms, processes, and stakeholders, and then provides detailed discussion and recommendations related to the coordination of benefits process. This process is very complex. It is important to understand the basic terminology involved before delving deeper into details. The paper also outlines situations that have been brought forward that may cause the coordination of benefits to be inaccurate or may cause inaccurate financial outcomes to Medicare Part D beneficiaries and/or supplemental payers.

The COB processes outlined in this document are based on CMS guidance issued to Part D Sponsors, SPAPs, ADAPs, and supplemental payers. NCPDP WG1 Information Reporting Problems Task Group has outlined these electronic transmissions and file exchanges critical to supplemental payment(s) after the Part D benefit has been billed.

Readers may refer to http://www.naic.org/committees_index_model_description_a_c.htm for additional information regarding payers that are primary to Medicare Part D. All payers are legally required to adhere to Medicare Secondary Payer (MSP) laws and any other Federal and State laws establishing payers of last resort (e.g., TRICARE). In all other situations, the Rules for Coordination of Benefits adopted in the most current National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation should be followed.

1.1 IMPORTANT REFERENCES

Recommendations for Effective 4Rx Usage in Medicare Part D Processing

http://www.ncdp.org/news_hipaa_trans_current.aspx#4RX

SPAP/ADAP BIN/PCN Guidance

http://ncdp.org/resources_spap.aspx

Pharmacy ID Card Fact Sheet

http://www.ncdp.org/PDF/NCPDP_pharmacy_id_card_fact_sheet.pdf

Pharmacy and/or Combination ID Card Implementation Guide

Available with NCPDP membership

NCPDP Telecommunication Standard Implementation Guide Version D.0

Available with NCPDP membership

2. ACRONYMS AND DEFINITIONS

The definitions of various terminology used within this document are provided for the reader to reference below. See also section “Appendix A. CMS File Definitions”.

4Rx DATA

The four data elements are used to process a pharmacy claim. In Medicare Part D, these four elements uniquely identify the Medicare Part D Sponsor for the beneficiary and are identified by the sponsor during beneficiary enrollment and exchanged with CMS contracted entities. The set of four elements are exchanged via eligibility verification, claims processing, and information reporting transactions, as well as post adjudication claim reporting functions. The 4Rx data are:

“RxBIN”	BIN Number
“RxPCN”	Processor Control Number
“RxGRP”	Group ID
“RxID”	Cardholder ID defined by the plan

It is recommended to read the NCPDP **Recommendations for Effective 4Rx Usage in Medicare Part D Processing** document for specific rules and usage for Part D Sponsors and plans supplemental to Part D.

CLAIM BILLING (B) TRANSACTIONS

B1 – Claim Billing

This transaction is used to request payment from the Processor for a specific patient for claims billed according to appropriate plan parameters. Claim Billing (B1) is a transaction request and a response.

B2 – Claim Billing Reversal

This transaction is used by the originator to cancel a claim that had been processed previously (i.e. to reverse a previously paid claim (B1)). If the reversal is processed on the same day that the request for payment was processed, a single claim record showing the final outcome will be reported back to the pharmacy on remittance information. If the reversal is submitted on a day or more following the date of the original claim processing, the pharmacy will see the paid claim and an offsetting adjustment for the claim on remittance information. Billing Reversal (B2) is a transaction request and a response.

B3 – Claim Billing Rebill

This transaction is a claim submission with an implied reversal of the same Service Reference Number. It is used by the originator to cancel a claim that had been processed previously, and to submit a new claim in the same transaction. A previously adjudicated claim is reversed and then the new claim is processed, using a two-step procedure in a single submitted transaction. Each part of the process works independently of the other. Claim Rebill (B3) is a transaction request and a response.

COB

In this context, Coordination of Benefits (COB) occurs when Medicare beneficiaries have a private and commercial insurer or coverage in addition to their Medicare coverage. The coordination of activities that result when multiple payers exist for claims to ensure the appropriate costs are paid by the responsible payer is considered coordination of benefits.

COB CONTRACTOR

The COB Contractor (COBC) is a federal contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of

Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.

ELIGIBILITY VERIFICATION (E1) TRANSACTION

This transaction is used by the originator to request that the Administrator, Processor, or Reporting Entity verify the eligibility of a specific patient according to appropriate plan parameters. This transaction is used to request verification of a patient's or cardholder's status for a given benefit program. Eligibility Verification (E1) is a transaction request and a response.

FINANCIAL INFORMATION REPORTING (FIR) TRANSACTIONS

The Financial Information Reporting is a process where by a patient, under one plan sponsor, has changed from one benefit plan PBM to another benefit plan PBM and point-in-time financial information is moved from the previous PBM to the new PBM. This information is necessary for the new PBM to accurately process claims and attribute plan balances and status for reporting to the plan sponsor. These are transactions in the NCPDP ***Financial Information Reporting Standard Implementation Guide***.

HEALTH INSURANCE CLAIM NUMBER (HICN)

The Social Security Administration (SSA) assigns all HICNs (commonly referred to as the Medicare ID number) and provides them to CMS for use by the Medicare program. A HICN is almost universally based on an individual's SSN. Eligibility to participate in Medicare is linked to eligibility to participate in the SSA program, but participation in one program is not absolutely dependent on eligibility to participate in the other. The Medicare tax (withholding) all employees pay during their working years is not linked to employee Social Security Administration withholding, for example. See also Railroad Retirement Board

The HICN is comprised of two parts:

1. Claim Account Number (CAN) – the policy number of the wage earner who earned Medicare benefits.
2. Beneficiary Identification Code (BIC) – identifies the current relationship between the beneficiary and the wage earner.

INFORMATION REPORTING (N) TRANSACTIONS

The Part D Transaction Facilitator transmits supplemental coverage information from payer-to-payer. The Transaction Facilitator process is triggered by the submission of a transaction by a pharmacy to a payer supplemental to a Part D Sponsor. The Information Reporting transactions Information Reporting (N1), Information Reporting Reversal (N2), and Information Reporting Rebill (N3) are used in this process and defined further in this document. These are transactions in the NCPDP ***Telecommunication Standard Implementation Guide***.

N1 - INFORMATION REPORTING

This transaction is used to transmit a record of supplemental coverage information related to a Part D beneficiary's liability. Information Reporting (N1) is a transaction request and a response.

N2 - INFORMATION REPORTING REVERSAL

This transaction is used to reverse a previously submitted N1 (Information Reporting) transaction. Information Reporting Reversal (N2) is a transaction request and a response.

N3 - INFORMATION REPORTING REBILL

This transaction is an Information Reporting submission with an implied reversal. It is used by the Originator to cancel an Information Reporting submitted that had been

processed previously, and submit a new Information Reporting in the same transaction. Information Reporting Rebill (N3) is a transaction request and a response.

OTHER HEALTH INFORMATION (OHI)

Other Health Information data provides the beneficiary's coordination of benefits detail information. CMS, through the COB Contractor, provides a data sharing partner with medical or prescription coverage from a beneficiary's other payer(s) and refers to this as data that identifies "other health information."

PART D SPONSOR

Part D sponsors are organizations contracted with CMS to provide Part D coverage. Most are Prescription Drug Plans (PDPs) or Medicare Advantage Plans that provide qualified prescription drug coverage (MAPDs). Plans may offer the following benefits: Defined Standard (DS); Actuarially Equivalent (AE); Basic Alternative (BA); Enhanced Alternative (EA). For more information about Part D Sponsors see www.cms.gov.

PART D TRANSACTION FACILITATOR

The Part D Transaction Facilitator is a federal contractor which is responsible, in conjunction with CMS, for establishing procedures for facilitating eligibility queries (E1 transactions) at point of sale, identifying costs reimbursed by other payers and alerting Part D sponsors about such transactions, and facilitating the transfer of TrOOP-related data when a beneficiary changes plan enrollment during the coverage year.

PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)

The amount by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D is reported to the CMS in defined fields of PLRO on the PDE. These dollars are to be deducted from TrOOP. Examples of such non-TrOOP eligible payers include group health plans, non-Part D government-funded programs (e.g., VA and TRICARE), and liability insurances (e.g., workers' compensation, home and auto).

PHARMACY BENEFIT MANAGER (PBM)

Typically a third-party administrator of prescription drug programs, PBMs can assist a plan sponsor to achieve the most effective utilization of prescription drug expenditures through benefit design, formulary management, rebate contracting, retrospective Drug Utilization Review (DUR), prospective DUR, network administration, and disease management. The PBM may also be a payer/processor or other entity that receives prescription drug claims, makes a decision regarding the level of reimbursement and sends the appropriate message or reject code back to the pharmacy/provider for action.

PRESCRIPTION DRUG EVENT (PDE)

A data transfer used to provide Part D claim information to CMS. All Part D sponsors are required to collect, submit, format, correct, and process all adjudicated claims to the Centers for Medicare and Medicaid Services (CMS). Through the submission of the PDE records, CMS provides Part D sponsors four mechanisms to pay plans for Part D basic benefits. The Prescription Drug Event (PDE) record is primarily structured to report data to make these four payments. The four payment mechanisms are the direct subsidy, low income subsidy, reinsurance subsidy, and risk sharing. Part D payment is risk based, but also has some cost components.

PROCESSOR

A Processor may be an insurer, a governmental program or another financially responsible entity or a third-party administrator or intermediary contracted on the behalf of those entities which receives prescription drug claims, makes a decision regarding the level of reimbursement to the provider, and transmits a response to the provider submitting a claim.

RAILROAD RETIREMENT BOARD

The Railroad Retirement Board (RRB) identifies its employees and retirees with claim numbers that consist of letter prefixes followed by either six or nine numeric digits. These claim numbers are incompatible with the claim number structure used in CMS' data processing systems. When a Medicare beneficiary falls under the jurisdiction of the RRB, the RRB claim number is converted by CMS to a HICN.

SWITCH/SERVICE INTERMEDIARY

A switch/service intermediary is an entity that connects pharmacies to processors in a standard manner in order to transmit transactions or files. The switch accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. A switch/intermediary may perform value added services including detailed editing/messaging of input/output data for validity and accuracy and translating data from one format to another.

TRUE OUT OF POCKET (TROOP)

TrOOP includes incurred costs for covered Part D drugs that are paid by the beneficiary, or by specified third parties on the beneficiary's behalf, up to the specified annual out-of-pocket threshold. Amounts that count toward TrOOP include:

- Payment made by the beneficiary, including payments for differentials (such as out-of-network differentials in situations involving emergency access.)
- Payments made by qualified third parties on the beneficiary's behalf, including qualified State Pharmaceutical Assistance Programs (SPAPs), qualified charities and manufacturer Patient Assistance Programs (PAPs), the Indian Health Service (IHS), AIDS Drug Assistance Programs (ADAPs), or by family, friends or other individuals.
- Low income cost sharing amounts ("Extra Help") paid by Medicare.

TrOOP excludes:

- Costs incurred for non-formulary Part D drugs unless treated by a sponsor as being included in the sponsor's formulary as a result of a coverage determination, redetermination, or appeal.
- Costs incurred for non-Part D drugs.
- Costs paid for covered Part D drugs obtained out-of-network when such access is inconsistent with the sponsor's out-of-network access policy.
- Costs paid for or reimbursed by insurance.
- Costs paid for or reimbursed by a government-funded health program, other than SPAPs and ADAPs or as specified above under the section "*Amounts that count toward TrOOP include*".
- Costs paid for or reimbursed by a group health plan.
- Costs paid for or reimbursed by another third party payment arrangement.
- Covered Part D drug cost-sharing waived or reduced by a pharmacy that is also a TrOOP-ineligible payer.

If a beneficiary switches Medicare Part D Sponsors during the plan year, their TrOOP will be transferred to their new plan -- it travels with the beneficiary.

3. STAKEHOLDERS INVOLVED IN THE COB PROCESS

1. Beneficiaries with coverage under a Part D Sponsor
2. Centers for Medicare and Medicaid Services (CMS)
 - a. Office of Financial Management.
 - b. Center for Medicare, including Medicare Drug Benefit Group- business owner for the Transaction Facilitation system, Medicare Enrollment and Appeals Group- business owner for the Medicare Beneficiary Database (MBD), and Medicare Plan Payment Group- business owner for the MARx
3. CMS' contractors
 - a. Coordination of Benefits Contractor (COBC): A federal contractor, currently, Group Health Inc. (GHI) an EmblemHealth Company. See section "*Acronyms and Definitions*".
 - b. Part D Transaction Facilitator (formerly TrOOP Facilitator): RelayHealth
4. Part D Sponsors: See section "*Acronyms and Definitions*".
5. Supplemental Payers: Any organization such as State Pharmaceutical Assistance Programs (SPAP), AIDS Drug Assistance Programs (ADAP), Medicaid, TRICARE, Veteran's Administration (VA), group health plans, Workers' Compensation, Auto/Life/Liability Insurance, Commercial group health plans, etc.
6. Pharmacies: Providers such as retail, mail, home infusion, specialty, long term care, post-acute care, Indian Tribal Unit, etc.
7. Switches/Intermediaries: See section "*Acronyms and Definitions*".
8. Pharmacy Benefit Managers (PBMs). See section "*Acronyms and Definitions*".
9. Section 111 Reporters: As per the Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007, all health insurers are now required to participate in data exchanges with CMS in order to provide CMS with additional information and an opportunity to determine their payment obligations. Insurers will receive Part D data entitlement information in a response file. Insurers determine if they must report by reviewing materials on the specific CMS Section 111 Website. See www.cms.gov/mandatoryinsrep. The reporting requirements derive from regulations found in the Federal Register 42 U.S.C.1395y(b)(7).
10. National Council for Prescription Drug Programs (NCPDP): An ANSI-accredited standards development organization serving the pharmacy services sector.

4. OVERVIEW OF MEDICARE COB REQUIREMENTS FOR PART D ENROLLEES

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L.108-173) was enacted in December 2003 and amended Title XVIII of the Social Security Act by establishing a new Part D: the Voluntary Prescription Drug Program effective January 1, 2006. Under the prescription drug benefit program, eligible Medicare beneficiaries are provided access to coverage options, including options with enhanced benefits, and additional beneficiary protections and assistance, such as access to negotiated prices, catastrophic coverage limits, and premium and cost-sharing subsidies for certain low-income beneficiaries. The requirements and recommendations in the following sections of this white paper flow from CMS regulations and policy guidance that are updated periodically and reflect the cooperation between CMS and the industry working in collaboration with NCPDP as required under 1860D-23(a)(4) of the Social Security Act.

Part D sponsors are required to coordinate with State Pharmaceutical Assistance Programs (SPAPs) and other providers of prescription drug coverage with respect to the payment of premiums and coverage, as well as coverage supplementing the benefits available under Part D. Entities that provide other prescription drug coverage with which Part D sponsors must coordinate include: Medicaid programs; group health plans; the Federal Employee Health Benefit Program; military coverage; the Indian Health Service (IHS); Federally qualified health centers, rural health clinics; other Part D plans; and other prescription drug coverage as CMS may specify. The MMA specified that these coordination requirements must relate to the following elements:

- Enrollment file sharing;
- Claims processing and payment;
- Claims reconciliation reports;
- Application of the protection against high out-of-pocket expenditures by tracking true out-of-pocket (TrOOP) expenditures; and
- Other processes that CMS determines.

When a Medicare Part D enrollee has other prescription drug coverage, coordination of benefits allows the plans that provide coverage for this same beneficiary to determine each of their payment responsibilities. This process is necessary in order to avoid duplication of payment and to prevent Medicare from paying primary when it is the secondary payer. As required by the MMA, Medicare secondary payer procedures apply to Part D sponsors in the same way as they apply to Medicare Advantage organizations under Part C. Regulations require Part D sponsors to report credible new or changed primary payer and supplemental prescription drug coverage information to the CMS COB Contractor; CMS guidance specifies that this reporting should be accomplished electronically via the Electronic Correspondence Referral System (ECRS) within 30 days of the sponsor's receipt of the information. Updated primary and supplemental coverage information reported to the COB Contractor is entered into CMS systems and CMS forwards the information as often as daily to the Part D Transaction Facilitator and Part D sponsors for their enrollees.

Under Part D, COB also provides the mechanism for support of the tracking and calculating of beneficiaries' "true out-of-pocket" (TrOOP) expenditures, or "incurred costs" as defined in the MMA and CMS' implementing regulations. Incurred costs under Part D include only costs incurred by the beneficiary for the annual deductible, or other cost-sharing prior to satisfying the out-of-pocket threshold, including the out-of-network price differential for which the individual is responsible when the emergency access requirements are met. Incurred costs are costs paid by the beneficiary, by another person on the beneficiary's behalf, by CMS on behalf of a low-income subsidy (LIS) eligible individual, or by a qualified SPAP, the IHS or an AIDS Drug Assistance Program (ADAP) that are not reimbursed through or paid under insurance or otherwise, a group health plan, or other third party arrangement. Incurred costs must be incurred for a covered Part D drug which is a Part D drug included in the individual's Part D plan's

formulary, or treated as being included as a result of a coverage determination or appeal, and obtained at a network pharmacy, unless emergency access provisions have been met. Part D sponsors must exclude costs that do not meet these requirements from a beneficiary's TrOOP.

Section 1860D-2(b)(4)(D) of the Act authorizes CMS to establish procedures for the exchange of information for determining whether costs reimbursed by third parties for Part D enrollees may be included in their TrOOP and for alerting Part D sponsors about such reimbursements. The TrOOP facilitation process developed by CMS and the industry in collaboration with NCPDP allows the majority of pharmacy claims processing and benefit coordination to take place in real-time at the pharmacy point of sale. CMS' Transaction Facilitator contractor, in conjunction with CMS, is responsible for establishing procedures for facilitating eligibility queries, identifying costs being reimbursed by other payers and reporting such transactions to Part D sponsors, and facilitating the transfer of TrOOP-related data when a beneficiary changes plans during the coverage year.

The CMS COB Contractor consolidates the activities that support the collection, management, and reporting of other coverage for Medicare beneficiaries. Through the data exchange processes, many payers voluntarily report information regarding prescription drug coverage they offer which is either primary or supplemental to Part D. In addition, many other insurers providing group health coverage, liability insurance, no-fault insurance, and workers' compensation, include prescription drug coverage in conjunction with their mandatory reporting under section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). A data exchange with CMS allows other payers:

1. To assist beneficiaries in fulfilling their statutory obligation to disclose third party reimbursement for Part D drug costs.
2. To avoid the cost of paying as primary when the payment should be secondary to Part D.
3. As a sponsor of record, to be notified if a paid claim is reversed or adjusted outside an on-line adjudication process.
4. If TrOOP-eligible, to cease payments for beneficiaries receiving the full low-income subsidy who reach the catastrophic phase of the benefit, since at that point, Medicare fully subsidizes the beneficiary's incurred costs for covered Part D drugs.

For this process to work, payers supplemental to Part D should obtain a unique RxBIN and/or RxPCN combination that will identify their paid claim responses for TrOOP tracking purposes when Part D is the primary payer. CMS also recommends that supplemental payers obtain an RxBIN and/or RxPCN combination unique to each separate plan they offer in order to distinguish each of their plans from one another. This allows each benefit plan to fulfill its obligation as a supplemental payer if it is identified on the COB file as secondary coverage. CMS guidance notes that for the COB and TrOOP tracking processes to function effectively, other payers should supply paid claims information to the Part D sponsor after making a payment that is supplemental to a Medicare payment. This will happen automatically only if the other payer reports their coverage information with the appropriate RxBIN and/or RxPCN combination to CMS thereby enabling the Transaction Facilitator to identify the supplemental payer's status. Therefore, it is critical that the RxBIN/RxPCN and Rx Cardholder ID (RxID) reported by the supplemental payer to the CMS COB contractor, entered into CMS systems and reported to the Transaction Facilitator matches the RxBIN/RxPCN and RxID on the supplemental claim request transaction. A match is required for the Transaction Facilitator to create the Information Reporting (N) transaction.

CMS requires that Part D sponsors coordinate benefits with supplemental payers that adhere to the CMS Data Sharing Agreement and transmit their eligibility data to CMS. Those supplemental payers that use the established on-line or batch COB process will derive the benefits associated with the creation of N transactions and their transmission to the beneficiary's Part D sponsor. Other supplemental payers that do not comply with the on-line or batch COB process forfeit COB and the benefits associated with it.

CMS regulations specify the requirements for plans sponsors to coordinate benefits with both other Part D plans when a Part D sponsor other than the sponsor of record paid claims for a beneficiary during the

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initial transition period and with other entities providing prescription drug coverage when that entity incorrectly paid as primary. Sponsors must follow CMS-established processes for plan-to-plan reconciliation in the former instances, and in the latter instances work directly with the other entities to achieve timely reconciliation.

Responsibility for Part D sponsors to account for other providers of prescription drug coverage when a retroactive claims adjustment creates an overpayment or underpayment is addressed in the Part D regulations. Part D sponsors must coordinate benefits with SPAPs and other providers of prescription drug coverage and appropriately adjudicate claims. Compliance with this requirement entails the sponsor not only coordinate benefits with other payers at POS, but also work with beneficiaries and other payers to resolve post-adjudicative payment issues arising from retroactive claims changes.

Retroactive claims adjustments can be necessitated by beneficiary changes (such as those resulting from retroactive LIS eligibility determinations, LIS status changes, or midyear Part D enrollment changes), sponsor receipt of other payer information, or errors in payer order. Some of these changes, those occurring within the payers' timely filing window, may be addressed through pharmacy-initiated reverse and rebill transactions. However, CMS guidance states that sponsors generally should limit requests for pharmacy reprocessing to those situations involving a payment error. All retroactive claims adjustments that cannot be addressed through pharmacy reverse and rebilling must be handled by the Part D sponsor through other means. Part D sponsors must determine whether or not any amount paid by any other payers was TrOOP-eligible and must adjust, as necessary, the affected beneficiaries' TrOOP balances.

CMS has established timeframes for Part D COB. Plan sponsors must coordinate benefits with SPAPs, other entities providing prescription drug coverage beneficiaries, and others paying on the beneficiaries' behalf for a period not to exceed 3 years from the date the prescription for a covered Part D drug was filled. CMS also requires that whenever a sponsor receives information that necessitates a retroactive claims adjustment, the sponsor must process the adjustment and issue refunds or recovery notices within 45 days of the sponsor's receipt of complete information regarding the adjustment.

Requirements for Part D COB are specified in statute and codified in Federal regulations. CMS Part D COB guidance is provided in Chapter 14 of the Medicare Prescription Drug Benefit Manual available on the CMS Web site at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter14.pdf>. This section does not supersede official CMS guidance, but is intended to convey a very general understanding of Part D COB requirements.

5. THE STEPS NECESSARY TO SUPPORT COORDINATION OF BENEFITS

In order to successfully coordinate benefits at point-of-sale, each entity involved must be electronically transmitting information. An on-line claims processor is typically used to adjudicate claims real time. Programs that are not using online processors or do not provide electronic batch files of prescription drug claims will not experience the efficiencies of coordination of benefits.

This section outlines the key steps of the data exchange process that supports coordination of Part D benefits. ***Please note that Part D Sponsors may subcontract with PBMs or Processors to perform certain services, such as claims processing. To simplify the reference to certain entities in this paper, the term “Part D Sponsor” may be used when the “PBM” or “Processor” is actually performing the specific function.***

5.1 PART D SPONSORS AND SUPPLEMENTAL PAYERS OBTAIN A UNIQUE BIN/PCN

5.1.1 BANK IDENTIFICATION NUMBER (BIN) OR ISSUER IDENTIFICATION NUMBER (IIN)

This is a six digit number (all six digits are significant) that is used for routing within the pharmacy industry. The BIN can be obtained through NCPDP or the IIN can be obtained through American National Standards Institute (ANSI). All references to BIN in this document generically refer to either the NCPDP or ANSI issued values. When used in the Medicare Part D processing environment it is referred to as RxBIN.

5.1.2 PROCESSOR CONTROL NUMBER (PCN)

This is a 10 character value that is typically assigned by the Part D Sponsor's processor and is also used for routing. When used in the Medicare Part D processing environment it is referred to as RxPCN.

5.1.3 REASON FOR UNIQUENESS OF THESE NUMBERS

The unique RxBIN and RxPCN help the Transaction Facilitator and Part D Sponsors recognize drug claim payments as TrOOP eligible. ID cards will need to be reissued once the RxBIN/RxPCN is obtained and prior to the effective date of plan coverage under the new RxBIN/RxPCN.

5.1.4 NOTIFICATION TO SWITCHES AND PHARMACIES OF THE NEW RxBIN/RxPCN

If the RxBIN is new, the Part D Sponsor or the supplemental plan must contact the switches 30 days prior to the effective date. If the RxBIN already exists, but the RxPCN is new, payer sheets must be sent to the switches and pharmacies noting the new RxBIN and/or RxPCN at least 30 days in advance. This allows the switches and pharmacies to update their systems prior to the date that the RxBIN/RxPCN will be used for on-line claim processing. NCPDP has created the “***Medicare Part D Plans Moving Processors White Paper***” which provides important information that should be referenced.

5.1.5 NOTIFICATION OF UNIQUE RxBIN/RxPCN COMBINATION TO NCPDP BY SUPPLEMENTAL PAYERS

If the RxBIN/RxPCN is new or has changed, supplemental payers must update or add their information to the NCPDP SPAP/ADAP BIN/PCN list. Refer to the SPAP/ADAP BIN/PCN Reference Guide for instructions on how to provide additions or changes at http://ncdpd.org/resources_spap.aspx.

5.2 THE DATA EXCHANGE PROCESS

5.2.1 DATA SHARING AGREEMENT BETWEEN SUPPLEMENTAL PAYERS AND CMS COB CONTRACTOR (COBC)

Information regarding requirements and file layouts can be found on the CMS website under the following links:

- Employer Voluntary Data Sharing Agreements
<https://www.cms.gov/Medicare/Coordination-of-Benefits/EmployerServices/employervdsa.html>
- Medicare Secondary Payer Group Health Plan Reporting

<http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/index.html?redirect=/MandatoryInsRep>

- Liability Insurance, Self-Insurance, No-Fault Insurance and Workers' Compensation
http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Liability_Self_No_Fault_Insurance_and_Workers_Compensation.html
- Coordination of Benefits Agreements (Insurer Reporting)
<http://cms.gov/Medicare/Coordination-of-Benefits/COBAgreement/index.html>
- Mandatory Insurer Reporting:
<https://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/index.html>
- ADAP and SPAP data sharing:
<https://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/index.html>

The CMS COB Contractor is the central recipient for all eligibility data exchanges and reporting of other insurance information for Medicare beneficiaries. All of the above file exchanges are performed on a either monthly or quarterly basis.

Coordination of Benefits Agreements are required for most of the data exchanges to protect the security, the integrity, and the confidentiality of the beneficiary's information. An agreement also allows the CMS COB contractor to share data for the purposes of coordinating prescription drug benefits and for the facilitation of electronic claims processing. Specifically, the CMS COB Contractor using MSP rules and the source of the data can define the correct payer order of other insurance information for beneficiaries who have other prescription drug coverage in addition to Medicare Part D. In the event that an organization is providing benefits and processing prescription drug claims on behalf of Medicare beneficiaries, the organization (or claims processor) should be using an electronic data exchange process to provide health or prescription drug coverage files to the CMS COB Contractor. More information about CMS' COB process may be found at http://www.cms.gov/COBPartD/01_overview.asp. Please refer to section "Appendix F. SPAP Eligibility File" and "Appendix G. ADAP Eligibility File" for additional information on the SPAP other health coverage file processes.

The sources for Part D supplemental coverage data are SPAPs, ADAPs, employers, insurers, and data entry to Electronic Correspondence Referral System (ECRS) by Part D Sponsors for non-SPAP/ADAP supplemental coverage. ECRS entries are reviewed and validated by CMS.

Note: SPAP/ADAP agreements require that the RxBIN/RxPCN used for Part D eligible beneficiaries be different from those that are non-Part D eligible.

5.2.2 DATA SHARING EXCHANGE BETWEEN SUPPLEMENTAL PAYERS AND CMS COB CONTRACTOR (COBC)

Once the data agreements are in place, the supplemental payers send other health coverage files to the COB Contractor.

The COB Contractor returns the other health coverage file to the supplemental payer indicating for each record whether the beneficiary is Part D or not. Part D beneficiary records include current effective and termination dates. The response file also contains unmatched records.

5.2.3 CMS COB CONTRACTOR (COBC) AND MEDICARE BENEFICIARY DATABASE (MBD)

The COB Contractor compiles data on a Medicare Part D beneficiary's other coverage that is primary or supplemental to Part D. This information includes the beneficiary's other coverage 4Rx data (RxBIN, RxPCN, RxGroup, RxID). The COB Contractor passes this data to CMS; the data is then loaded into CMS' Medicare Beneficiary Database (MBD).

5.2.4 CMS SHARING ELIGIBILITY DATA WITH THE PART D SPONSORS

Part D Sponsors receive other prescription health insurance coverage information from CMS. CMS provides information from the Medicare Beneficiary Database (MBD) along with the Part D record (commonly referred to as the COBC file) to Part D Sponsors. The COBC file is provided to the Part D Sponsors daily if there are updates. A full file refresh of the COBC data for each beneficiary provided to the Part D sponsors is performed annually.

Part D Sponsors can receive this information from the COBC through the COB file from MARx or the data may be sent to their Pharmacy Benefit Manager (PBM) or processor. In order to provide efficiency and timely coordination of benefits, Part D Sponsors may also authorize CMS to send the COB file directly to their PBM or processor. Part D Sponsors who receive the COB file from CMS, directly, must send the data to their PBM or processor.

The COB data is used by the PBM of the Part D Sponsor (or their designated processor) to provide other insurance information back to the pharmacy on the claim response. This allows for electronic coordination of benefits, real time.

5.2.5 CMS SHARING ELIGIBILITY DATA WITH THE TRANSACTION FACILITATOR

CMS provides a file to the Transaction Facilitator (commonly referred to as the CMS Eligibility File). The file is provided nightly if there are updates. The file contains Part D records, Part A, Part B, PACE and demonstration programs and other coverage information (see section “*Appendix B. Building Eligibility History for Medicare Beneficiaries Diagram*”).

The Transaction Facilitator uses the coverage information to create Information Reporting (N) transactions to be transmitted to the Part D Sponsor (as explained in section “*Appendix D. Supplemental Claim Processing Flow for Coordination of Benefits for Medicare Part D Diagram*”).

5.3 CLAIMS PROCESSING

5.3.1 PHARMACY CHECKS ELIGIBILITY INFORMATION

A pharmacy should submit an NCPDP Eligibility Verification (E1) transaction to the Transaction Facilitator to determine Medicare Part D Sponsor enrollment. This should occur if the beneficiary's ID card is not present, has the wrong ID number, an old ID card is on file with the pharmacy, or the pharmacy wishes to verify the information on the patient's profile.

The Eligibility Verification response from the Transaction Facilitator will return enrollment information to the pharmacy, including any Part D payer information as well as any payer-specific information about any Other Health Insurance (OHI) drug coverage identifiers, in the payer order submitted to CMS by the data sharing entities.

Pharmacies also submit an E1 to check Medicare Part A and/or Part B eligibility.

5.3.2 PHARMACY SUBMITS CLAIM TO PART D SPONSOR. PART D SPONSOR RETURNS THE PART D CLAIM COVERAGE AND SUPPLEMENTAL PAYER 4Rx DATA ON THE CLAIM RESPONSE

A Part D beneficiary's claim is submitted by the pharmacy or beneficiary (paper claim in rare instances) for adjudication under a Part D benefit.

1. The pharmacy submits an NCPDP Claim Billing (B1) transaction to the Part D Sponsor.
2. The Part D Sponsor adjudicates the claim and returns a claim response to the pharmacy with OHI (Other Health Insurance) information to instruct the pharmacist that other payers may need to be billed.

Pharmacies will use this OHI 4Rx data from the claim response, or from Eligibility Verification (E1) transaction response or from data provided by the beneficiary to determine which plan to bill next. It is critical that pharmacies submit supplemental claims to other payers using the same 4Rx data that CMS has on record for the beneficiary. This ensures that the Transaction Facilitator can

capture the supplemental Claim Billing (B1) transaction and response for generation of an Information Reporting (N1) transaction.

Specific fields in the Response COB/Other Payers Segment are used to identify OHI 4Rx data:

- Other Payer ID (34Ø-7C),
- Other Payer Processor Control Number (991-MH),
- Other Payer Cardholder ID (356-NU) and
- Other Payer Group ID (992-MJ).

See “Appendix C. Medicare Part D Primary Claim Processing Diagram” for the flow of Primary Part D claim processing.

5.3.3 PHARMACY BILLS THE SUPPLEMENTAL PAYER

1. If other coverage is known, the pharmacy will then generate a secondary NCPDP Claim Billing (B1) transaction to any other supplemental payers.
 - a. The pharmacy obtains the OHI data from an Eligibility Verification (E1) transaction response, OHI data in the claim response or based on ID card information on the beneficiary’s pharmacy profile.
2. This claim request is routed to the Transaction Facilitator if the RxBIN/RxPCN is on the switch routing list for supplemental payers. The 4Rx data on the claim must match what the supplemental plan submitted to the COB Contractor
 - a. If the 4Rx data on the claim does not match, the Transaction Facilitator will be unable to send the N transaction to the Part D Sponsor to update the beneficiary’s TrOOP.
3. The supplemental payer adjudicates the claim and sends a response back to the pharmacy.
4. This claim response is routed to the Transaction Facilitator if the RxBIN/RxPCN is on the switch routing list for supplemental payers.
 - a. The Transaction Facilitator uses data from the secondary claim to do an eligibility match. If a match is found, an N transaction is sent to the Part D Sponsor. See section “Appendix H. Matching Logic Provided by Transaction Facilitator”.

5.4 CREATION OF THE INFORMATION REPORTING TRANSACTION “THE N”

5.4.1 TRANSACTION FACILITATOR “N” CREATION AND TRANSMISSION OF SUPPLEMENTAL CLAIM INFORMATION TO THE PART D SPONSOR – REAL TIME

The Intermediaries/Switches forward the claim (request and response) to the Transaction Facilitator if the RxBIN/RxPCN is on the routing table. The Transaction Facilitator captures the supplemental claim request transaction sent by the pharmacy and the response transaction returned by the supplemental payer. The Transaction Facilitator attempts to find the beneficiary from the CMS Eligibility File by:

1. Attempting to find a supplemental payer eligibility record with the same RxBIN/RxPCN and RxID that is on the supplemental claim request for the date of service on the claim.
 - a. If a match is found then the Transaction Facilitator continues to Step 2 below.
 - b. If a match is not found and the RxBIN/RxPCN on the supplemental claim request is on the SPAP/ADAP RxBIN/RxPCN list, then an attempt to match the request using the schedule defined in section “Appendix L. Retry of N Transactions by the Transaction Facilitator”. If the RxBIN/RxPCN is not on the SPAP/ADAP list, the Transaction Facilitator ceases processing.
2. Once the supplemental OHI is found, the Transaction Facilitator then searches for the Part D record associated with the supplemental record for that date of service on the claim request.
 - a. If a match is found the Transaction Facilitator continues to Step 3.
 - b. If a match is not found and the RxBIN/RxPCN on the supplemental claim request is on the SPAP/ADAP RxBIN/RxPCN list, then an attempt to match the request using the schedule defined in section “Appendix L. Retry of N Transactions by the Transaction Facilitator”. If the RxBIN/RxPCN is not on the SPAP/ADAP list, the Transaction Facilitator ceases processing.

3. The Transaction Facilitator will create an Information Reporting (N) transaction that is forwarded to the Part D Sponsor. This transaction contains the necessary information from both the supplemental claim request and the response to report the amount the beneficiary paid after the supplemental payer processed the claim. See section “*Appendix J. Information Reporting Transaction Flows*” for the information contained in the N transaction.

It is critical that the RxBIN/RxPCN/RxID reported to the COB Contractor (which is then loaded to the CMS Medicare Beneficiary Database and provided to the Transaction Facilitator) matches the RxBIN/RxPCN/RxID on the supplemental claim request transaction. If these data elements do not match the Transaction Facilitator cannot create the Information Reporting (N) transaction. The Transaction Facilitator stores claims that are not matched in a separate file referred to as the “non-matched.” More information on the Transaction Facilitation process may be found on the Transaction Facilitator’s website at <https://medifacd.relayhealth.com/>. See section “*Appendix H. Matching Logic Provided by Transaction Facilitator*” for information on how the Transaction Facilitator matches the supplemental claim to their eligibility database in order to send the Information Reporting (N) transaction to the Part D Sponsor of Record.

To summarize, in order to participate in the COB online process a supplemental payer must provide accurate eligibility information to the COB Contractor. In order to ensure Information Reporting (N) transactions can be generated the supplemental payer should require an exact match between the RxBIN/RxPCN/RxID submitted on the POS claim and the data that is submitted to the COB Contractor. Claims that do not match should be rejected by the supplemental payer. If the supplemental payer is unable to support the actions above, or accepts claims with other than the RxBIN/RxPCN/RxID submitted to the COB Contractor then it is important that the supplemental payer provide Information Reporting (N) transaction information that reflects the CMS 4Rx data to the Transaction Facilitator. This will allow the Transaction Facilitator to transmit the Information Reporting (N) transaction to the appropriate Part D Sponsor.

If the supplemental payer is not processing claims online, then they will need to provide batch N transactions which must contain the same 4Rx data submitted to the COB Contractor.

5.4.2 TRANSACTION FACILITATOR “N” CREATION AND TRANSMISSION OF SUPPLEMENTAL CLAIM INFORMATION TO THE PART D SPONSOR – BATCH

Transaction exception processing is referred to as TrOOP Batch Transactions. The transactions will not be forwarded to the Transaction Facilitator through the “normal” process above.

TrOOP Batch File Required When

1. The supplemental payer will not mandate the RxBIN/RxPCN/RxGroup/RxID submitted on the claim matches what is submitted to CMS due to concerns about beneficiary disruption.
2. The supplemental payer allows their beneficiaries to submit paper claims. Since paper claims are paid directly by the supplemental payer without pharmacy or switch involvement, the only available method for communicating payment of paper claims is via the batch file process.
3. The supplemental payer has a direct connection to a pharmacy. In this situation, the pharmacy does not use a switch to submit their claims to the supplemental payer.
4. The supplemental payer does not process claims in real-time or batch, and does not have a processor that performs these functions.
5. The original claim did not match the OHI in the database. The supplemental payer needs to correct the OHI and recycle claims to be in sync.
6. The original claim supplemental copay has been adjusted offline (not through electronic pharmacy transaction). The supplemental payer needs to correct the copay in order for TrOOP to be updated.

5.4.3 SET UP FOR SUBMITTING BATCH FILES

- Step 1** If the supplemental payer is not currently sending Version D.0 CMS Part D Supplemental Information Reporting (N Transaction) Batch Files they will need to contact RelayHealth at TBTSupport@relayhealth.com and indicate they would like to send batch transactions. Proceed to step 2.
- Step 2** The Supplemental Payer will need to set up a secure connection with RelayHealth to transmit the batch files. The first step to this process is to complete the “Medicare Part D Supplemental N Transaction Batch File FTP Information” form located at www.MediFacD.com and once completed, the form is sent to the TBTSupport@relayhealth.com e-mail address. If the supplemental payer has connectivity, proceed to step 3.
- Step 3** If the supplemental payer has connectivity set-up with RelayHealth, the supplemental payer using the “Batch v1.2 Specifications for Payers Supplemental to Part D” (Refer to MediFacD web site for batch specifications implementation guide and payer sheet) will schedule a time to test a small set of transactions to confirm the file format and transmission are successful and eligibility match can be found. Provided the test is successful, proceed to step 4.
- Step 4** The Supplemental payer schedules their batch file. Daily submission is strongly recommended, however the files should be submitted no less than weekly.

The batch file format information can be found at http://www.ncpdp.org/resources_spap.aspx.

5.5 PART D SPONSOR ASSOCIATES THE INFORMATION REPORTING TRANSACTION TO THE PART D CLAIM

1. The Part D Sponsor receives the Information Reporting (N) transaction and attempts to match the N data with a corresponding Part D claim.
 - a. Once the beneficiary has been identified, the Part D Sponsor determines the status of the supplemental payment on the Information Reporting (N) transaction as either qualified or non-qualified based on the “Supplemental Type” field identified on the OHI record sent on the COB file by CMS. The other payer payment amount is computed by comparing the Part D Sponsor beneficiary liability to the amount of the beneficiary liability from the supplemental payer(s) to determine if the supplemental payer affects the beneficiary’s TrOOP. Information Reporting transactions ensure that Part D Sponsors are aware that a supplemental payer has been involved in the claims process and must be considered when undertaking post adjudicated adjustments.
 - i. If the dollars are qualified, the Part D Sponsor ensures that the beneficiary’s TrOOP accumulations include the amount paid by the supplemental payer. These are reported under “Other TrOOP” field on the PDE.
 - ii. If the dollars are non-qualified, the Part D Sponsor ensures the beneficiary’s TrOOP will be reduced and reported in “PLRO” field on the PDE.
 - iii. Instruction to Part D Sponsors on determination of qualified or non-qualified payments is included in the PDE guide. The current PDE instructions are found at: [http://csscooperations.com/Internet/Cssc3.Nsf/files/PDE%20Return-Outbound%20Report%20File%20Layout%20Effective%20February%2028-2013.xls/\\$File/PDE%20Return-Outbound%20Report%20File%20Layout%20Effective%20February%2028-2013.xls](http://csscooperations.com/Internet/Cssc3.Nsf/files/PDE%20Return-Outbound%20Report%20File%20Layout%20Effective%20February%2028-2013.xls/$File/PDE%20Return-Outbound%20Report%20File%20Layout%20Effective%20February%2028-2013.xls)

IMPORTANT NOTE: When all of the pieces of this flow are done correctly, the Part D Sponsor will be able to coordinate per CMS requirements including any post adjudicated adjustments with supplemental payers. This coordination determines what amount, if any, of a Part D beneficiary’s cost sharing should be refunded to or recouped from a supplemental payer or a beneficiary. Refer

to section “**Appendix K. How N Transactions are Applied by the Part D Sponsor**” for further details about how N transactions are applied by the Part D Sponsor.

6. INDUSTRY ISSUES PRESENTED TO NCPDP

The issues below have been presented to the NCPDP Information Reporting Problems Task Group to present educational information to the Part D Sponsors, PBMs, and supplemental payers. The recommendations, as listed below, are current at the time of this publication.

6.1 ***CARDHOLDER IDs THAT ARE INCONSISTENT BETWEEN THE DATA EXCHANGES***

One of the primary keys to accurate coordination of benefits is the Transaction Facilitator, CMS data files, supplemental plans and PBMs supporting Medicare Part D beneficiaries have accurate current, future and historical Cardholder IDs on file. In addition, it is equally important to understand that accurate coordination of benefits requires all plans to provide historical eligibility timelines of coverage for the Part D beneficiary. Coordination of benefits uses various data elements to identify matched other insurance records within various systems. To help illustrate an example, the creation of an N transaction requires data matching between the Transaction Facilitator, the Supplemental Payer, and the Part D Sponsor. The Transaction Facilitator must use the supplemental cardholder ID from the pharmacy claim transaction (on-line or batch) to find the Part D beneficiary cardholder ID within the CMS systems. Matched records will be forwarded to the Part D Sponsor of record based on the fill date of the claim. It is important to note that if any of the data is out of sync, the data match may not work and may result in an outcome that was not expected. The correct cardholder ID must be used on the claim. See section “*Appendix H. Matching Logic Provided by Transaction Facilitator*”.

NCPDP WG1 Information Reporting Task Group has studied several issues where TrOOP dollars were not flowing through the process correctly. These inconsistencies may cause Medicare Part D to post the TrOOP financial accumulators differently than expected for some of their Part D beneficiaries.

Some of the challenges that occurred specific to the cardholder ID were precipitated by the restriction of SSN, HICN and RRB identifier usage mandated by the government. As a result of the restriction, identifying the same individual without using a common identifier has made the coordination of benefits process more challenging. As a result, health plans/programs and Part D Sponsors/programs created proprietary Cardholder IDs for their beneficiaries and then engineered their systems to use this number. Part D plans are required to assign a unique number to each beneficiary because each beneficiary is considered an individual subscriber to Medicare. This unique plan-assigned number is typically provided by the Part D plan (or their eligibility vendor) to the PBM for drug claims processing. A change in the beneficiary ID by any plan can cause downstream impacts to coordination of benefits efforts and TrOOP accounting if not appropriately and effectively communicated.

Currently, non-Part D sponsors also create a plan-assigned beneficiary identification number. Non-Part D sponsors may choose to concatenate a suffix to the same ID assigned to all members within a family. Non-Part D Sponsors using this approach should ensure that the beneficiary's ID card displays the exact Cardholder ID that is required on the pharmacy-submitted claim and reported to the COB Contractor. Any deviation from this process, e.g., dropping the suffix in any part of this process, will cause problems with matching the eligibility on the supplemental payer's claim to the other health insurance information on file with CMS in order to generate an N transaction.

It is important for any and all changes in a beneficiary identification number to be appropriately and effectively communicated in data exchanges with CMS. It is also critical that processors implement pharmacy edits requiring pharmacies to use the appropriate ID based on the date of service of the claim. In addition, the Cardholder ID used for pharmacy claims processing must be in alignment with the beneficiary ID sent to CMS in the data exchange processes.

Below is a table that provides the name of the various data exchanges (source CMS).

Entity/Insurer Type	Agreement name	File name
SPAP	State Pharmaceutical Assistance Program Data Sharing Agreement (SPAP DSA)	State Pharmaceutical Assistance Program (SPAP) Input file
ADAP	Supplemental Drug Program Data Sharing Agreement (SDP-DSA) aka ADAP DSA	Supplemental Drug Program (SDP) Input File
PAP	Patient Assistance Program	Patient Assistance Program (PAP) Input File
Employer	Employer Voluntary Data Sharing Agreement (VDSA)	Primary Drug: MSP Input File, Supplemental Drug: Non-MSP Input File
Section 111	MMSEA Section 111 MSP Mandatory Reporting	Primary Drug: MSP Input File, Supplemental Drug: Non-MSP Input File
COBA	Coordination of Benefits Agreement (COBA)	E02 Eligibility File

Because all of these data exchanges have a cardholder ID, it is imperative that the supplemental payers use the same identification number in the above file exchanges.

As described earlier, the successful creation of N transactions is dependent on valid 4Rx data and proper claim editing at the Part D Sponsor. If the beneficiary ID on the downstream payer's claim does not match the Transaction Facilitator's beneficiary ID, the claim will be stored in non-matched file maintained by the Transaction Facilitator and the N transaction will not be created. The Part D Sponsor is unaware that the supplemental plan has paid a portion of the beneficiary's cost share.

All Part D sponsors must coordinate benefits with other payers and correctly calculate TrOOP in order to properly administer the Part D benefit. The functionality to permit the exchange of information between Part D sponsors and supplemental payers essential for COB and TrOOP tracking exists only within the Part D Transaction Facilitation process. Thus, Information Reporting transactions and Financial Information Reporting transactions generated by the Transaction Facilitator must be received and processed by plan sponsors, the data entered into sponsor systems and used for benefit administration and reporting.

Problem Statement: Cross-Referencing and Use of Old and New Cardholder IDs. Issues have been reported that the usage of an alternate identification number has caused mismatched records between the identification number on the claim and the identification number stored on the CMS systems. These situations have caused non-matched records to occur.

Processors whose clients have re-enumerated their beneficiaries have traditionally stored the former identification number in their systems. Processors may use the previous identification number as an alternate ID to help minimize disruption to the pharmacy and the beneficiary until the new identification number has been presented at the pharmacy. This alternate identification number has also minimized disruption to pharmacies because, in some cases, the old ID number could be kept in the pharmacy system's patient profile and required no changes in order to process a claim with the new identification number.

Some supplemental plans are sending one ID number to the COB Contractor, but allowing the pharmacy to send multiple ID numbers for the same beneficiary. Examples are provided below:

The COB Contractor file contains one cardholder ID. The pharmacy system contains one or more cardholder IDs. The Processor files contain two cardholder IDs and allows either ID to be sent on the claim. If the claim is paid using ID B9876543, the COB Contractor does not have visibility to this ID and accumulators will not be updated.

To the COB Contractor:	Cardholder ID A12345678
The pharmacy sends on the claim:	Cardholder ID A12345678 or B9876543

Problem Statement: Part D Sponsors or supplemental plans may include prefix or suffix numbers on their Identification Cards. These additional characters (before or after the ‘core’ ID) may or may not be entered by the Pharmacist and may or may not be required on the Pharmacy claim.

Pharmacies are often provided payer sheets to assist with the data entry of the identification number.

If the identification number used on a claim does not match the ID number used in adjudication by the Part D or supplemental claims processor, this mismatch can cause downstream impacts on the ability to pair a Medicare Part D transaction to the supplemental transaction in order to track True Out of Pocket expenses (TrOOP).

Suffix (often referred to as Person Code) example is provided below:

To the COB Contractor:	Cardholder ID A12345678
The ID card displays:	Cardholder ID A12345678 01 (a space may or may not be inserted between the cardholder ID and suffix)
The pharmacy sends on the claim:	Cardholder ID A12345678 OR A1234567801

In this example, the processor allows the claim to be submitted with the 01 person code appended onto the Cardholder ID. This does not match the Cardholder ID sent to the COB Contractor. This is further complicated when the ID card contains a value different than what is sent to the COB Contractor.

Prefix example is provided below:

To the COB Contractor:	Cardholder ID A12345678
The ID card displays:	Cardholder ID XYZ A12345678
The pharmacy sends on the claim:	Cardholder ID A12345678 OR XYZ A1234567801

In this example, the processor allows the claim to be submitted with the XYZ prefix appended onto the Cardholder ID. This does not match the Cardholder ID sent to the COB Contractor. This is further complicated when the ID card contains a value different than what is sent to the COB Contractor.

CMS requires that:

1. Part D Sponsors assign a unique beneficiary ID for all of their Medicare beneficiaries.
2. Part D Sponsors must require pharmacies submit the Cardholder ID that they submitted to CMS following enrollment.

Recommendation: CMS issued guidance to Medicare Part D Sponsors (Clarification of Unique BIN (or BIN/PCN) Requirements as of January 1, 2012 [§423.120(c)(4) as revised by CMS-4085-F] November 12, 2010) requiring any internal processes that allowed mapping of IDs or the use of alternate IDs in searches to retire this logic. In its place, exact matching on beneficiary ID is required. Identification exchanged with other entities must be an exact match. This logic was required to be in place and enforced effective on March 31, 2012. As noted above, supplemental payers should follow the same set of rules required by CMS of the Part D Sponsor.

If supplemental plans determine that N transactions were not created due to misaligned Cardholder IDs or effective dates, batch N transactions should be created and sent to the Transaction Facilitator with the same ID that was sent to the COB Contractor. For those who have not been set up, see section “*Set Up for Submitting Batch Files*” above.

See document ***Recommendations for Effective 4Rx Usage in Medicare Part D Processing***.

NCPDP presented a webinar on the effective usage of the 4Rx data, or data used to route Medicare Part D claims in the pharmacy industry. This webinar contains useful information in regards to the beneficiary identification number. See http://www.ncdp.org/news_hipaa_trans_current.aspx

6.2 CHANGE IN BENEFICIARY ID AT THE SUPPLEMENTAL PAYER

Problem Statement: Three supplemental payers reported TrOOP issues with Medicare Part D beneficiaries. Each payer had identified beneficiaries that were not properly moving through the stages of the Part D benefit.

Through investigation of the specific issues brought to the NCPDP Information Reporting Problems Task Group's attention, it was determined that some supplemental claims had been paid but no N transaction was created. The file sent to the COB contractor by the SPAP/ADAP is a full file replacement. As a result, the COB Contractor creates a snapshot of each beneficiary's eligibility. Therefore, a change to the supplemental payer cardholder ID at any point of the year must be reported to the COB contractor with correct effective and termination dates for all changes within that cardholder ID for the same beneficiary over a three year timeframe. The effective and termination dates should also coincide with the supplemental payers claim adjudication edits as it relates to requiring a cardholder ID for the applicable date of service (illustrated below in the example). N transactions will be recorded as 'non-matched' if the cardholder effective and termination dates are not reported to the COB contractor correctly. N transactions will be run through a retry process at RelayHealth in the event the eligibility records are corrected. Upon correction of the eligibility data to the COB contractor, the N transactions will be created and sent to the Part D Sponsor. See "Appendix L. Retry of N Transactions by the Transaction Facilitator" for further explanation of the RelayHealth 'retry' processing.

Example provided below illustrating the problem.

Supplemental Payer Eligibility:

John Smith	Cardholder ID 123456	effective 01/01/2011 – 05/31/2011
John Smith	Cardholder ID 456789	effective 06/01/2011 – 12/31/2011

To the COB Contractor:

John Smith	Cardholder ID 456789	effective 01/01/2011 – with a term date of 12/31/2011 (which does not follow the full file replacement rules)
------------	----------------------	---

The pharmacy sends on the claim:

John Smith	Cardholder ID 123456	with a date of fill of 6/02/2011 which is accepted by the supplemental plan rather than rejecting and enforcing Cardholder ID 456789
------------	----------------------	--

Recommendation: The identification of the beneficiary stored in eligibility files (Supplemental payer eligibility systems and COB Contractor) identified above must match the identification of the beneficiary that was transmitted by the pharmacy for claims processing. Supplemental plans must diligently exchange any and all changes in beneficiary ID number in the CMS data exchange. The expired cardholder ID must be sent to the COB contractor with a termination date. The new cardholder ID must be sent with the effective date as illustrated below.

Supplemental Payer Eligibility:

John Smith	Cardholder ID 123456	effective 01/01/2011 – 05/31/2011
John Smith	Cardholder ID 456789	effective 06/01/2011 – 12/31/2011

To the COB Contractor:

John Smith	Cardholder ID 123456	effective 01/01/2011 – 05/31/2011
John Smith	Cardholder ID 456789	effective 06/01/2011 – 12/31/2011

The pharmacy sends on the claim:

John Smith	Cardholder ID 123456	With a date of fill of 06/02/2011 which should be rejected by the supplemental plan and therefore should enforce Cardholder ID 456789. Cardholder ID 456789 with a date of fill of 06/02/2011 which would be adjudicated by the supplemental plan.
------------	----------------------	--

When ID number changes are needed, the supplemental plans should change identification numbers effective on the first of the year (January 1st). If this cannot be done, the supplemental plan must send the new beneficiary identification number to the CMS COB Contractor using the file layout specified in the data sharing agreement with CMS. This file must be sent with an effective and term date, as appropriate, for each beneficiary identification number. Refer to appendices F and G for additional information.

If supplemental plans determine that N transactions were not created due to misaligned Cardholder IDs or effective dates, batch N transactions should be created by the supplemental plans and sent to the Transaction Facilitator. See section “Set Up for Submitting Batch Files” above for information related to setting up the batch file process.

Not following the above recommendations can cause negative impacts to the beneficiaries within Part D when Part D sponsors adjust claims using the new/updated OHI. Beneficiaries may receive refund checks for payment originally made by supplemental payers that later may be determined to be incorrectly issued. Part D sponsors, as a result may need to recoup these monies. Part D sponsors also have to make claims adjustments that are unnecessary if the supplemental eligibility data was sent correctly.

6.3 INCONSISTENT HANDLING OF THE COB FILE BETWEEN PART D SPONSORS AND PROCESSORS

Problem Statement: Due to how the COB file is handled, the OHI data can be out of sync between the Part D Sponsor and their subcontractor used for COB file services. This OHI information can be used when the Part D Sponsor attempts to apply the N transaction and/or attempts to provide messaging to pharmacies related to supplemental coverage.

This issue is specific to the file that is passed from the CMS MARx system to Part D Sponsors or their subcontractor, referred to as the “COB File.” The COB File does not contain the Part D Sponsor’s 4Rx data which is commonly used in other circumstances, e.g., 4Rx data is required on the Part D pharmacy claim to find the beneficiary (as explained in this white paper) and within the Part D Transaction Facilitator for routing of N transactions. The header record of COB File is limited to the following data elements (listed below) to help identify the Part D beneficiary. This file also contains coverage that is primary and supplemental to Part D.

Item	Field	Size	Position	Format	Valid Values/Description
1	Record Type	3	1-3	CHAR	"DTL"
2	HICN/RRB Number	12	4-15	CHAR	Spaces if unknown
3	SSN	9	16-24	ZD	000000000 if unknown
4	Date of Birth (DOB)	8	25-32	CHAR	YYYYMMDD
5	Gender Code	1	33-33	CHAR	0=Unknown, 1 = Male, 2 = Female
6	Contract Number	5	34-38	CHAR	
7	Plan Benefit Package	3	39-41	CHAR	
8	Action Type	1	42-42	CHAR	2 = Full Replacement
9	Filler	958	43-1000		

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The fields above reside in the header record which is part of the file that CMS sends all Part D sponsors comprised of other prescription insurance information about their beneficiaries. The file can be sent to Part D sponsors as frequently as daily. The intent of CMS is this file will be processed as a replacement file for the beneficiaries on the file, and forwarded to their claims processor for use of messaging COB information back to the pharmacy, and for Part D Sponsors to process N transactions. Refer to the Plan Communication User Guide for the latest version of the complete COB file layout which can be found at <http://www.cms.gov>

The following problems have been presented to the NCPDP task group:

1) Delay of posting COB records: There is limited information for matching provided on the header record which makes it difficult for the processor to identify the beneficiary because the only identification number used is the HICN. Some Part D Sponsors may be modifying the COB file to include the 4Rx data prior to sending to their PBM. Part D Sponsors or their PBM must match the file against their enrollment systems and find the corresponding beneficiary ID number. The research needed to correctly identify beneficiary records may cause a delay of posting the COB records to the processor's systems.

2) Misinterpretation of full file rules: This is a full file replacement file that the Part D Sponsor uses to update their COB data. However, due to different interpretations of the handling of the COB file, the records expected in the three year historical period may not be not exchanged and/or applied consistently.

Recommendation: When COB data at the PBM and Part D Sponsor are not in sync with the CMS COB data, the calculation of the beneficiary's TrOOP and the ability of the supplemental plan to participate in post-adjudication financial reconciliations after claims have been reprocessed may be affected. Data from the COB file regarding the beneficiary's other coverage also enables the pharmacist to bill the other payers which may result in a reduction in the beneficiary's out-of-pocket expense at point-of-sale. At the time this white paper was published, NCPDP has several task groups currently exploring when COB data may not have been applied correctly to determine if additional instructions should be developed, or a change to the process is warranted. CMS published guidance explaining the rules that Part D Sponsors must follow on how the COB files are applied to PBM systems. To access the latest information, see <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/HPMS-Guidance-History.html> and search on "Coordination of Benefits." The file layout of the COB data can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoCOBFile_112408.pdf. The layout of the COB file can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelphdesk/Downloads/PCUG_v6_2_Appendices_Final_08292012.pdf

6.4 SUPPLEMENTAL SPAP OR ADAP IS NOT IDENTIFIED AS QUALIFIED

Problem Statement: N transactions are sent to the Part D Sponsor by the Transaction Facilitator. The Part D Sponsor compares the N transaction to the COB file to determine the qualified/non-qualified status of the supplemental payer. The field on the COB file that determines the qualified/non-qualified status is labeled the Supplemental Type Code. Dollars contributed to qualified payers were not being applied to TrOOP because of the issues cited below.

Part D Sponsors are required to send a 30-day COB notification to new enrollees and an annual COB notification to current enrollees. These notifications are sent only to new and current enrollees with existing other prescription drug coverage on the COB file received from CMS. Each enrollee is notified of the other coverage reflected for him or her on the COB file and is requested to review the information and report back only updates (that is, corrections to existing information and new coverage) to the sponsor. Credible new or revised information must be sent to the CMS COB Contractor via ECRS within 30 days of receipt. Information is "credible" if consistent with conventions for how group health insurance coverage is identified; e.g., information that includes the name and address of the insurer and the policy identification number.

Collection of 4Rx data is extremely important for correct identification of the insurer and insured.

Recommendation: NCPDP has presented a webinar to SPAPs and ADAPs in the industry along with Part D Sponsors and PBMs to relay the importance of the RxBIN/RxPCN usage for Part D supplemental claims. This webinar outlines a business need for the Transaction Facilitator to know to look for claims processed by these entities and help recycle transactions back through when non-matched records occur due to timing issues. The webinar is free and publicly available at the following location: http://ncdpd.org/resources_spap.aspx

NCPDP, with approval of CMS, has created an RxBIN/RxPCN spreadsheet for all qualified SPAPs and ADAPs. Part D Sponsors are encouraged to use this list in the following methods:

1. When Part D Sponsors are collecting COB information on the Medicare Part D annual coordination of benefits verification survey (explained in #1 above) the NCPDP SPAP ADAP BIN/PCN spreadsheet may be used to determine the payer's status based on the RxBIN/RxPCN combination reported by the beneficiary. If the payer is found on the spreadsheet, the supplemental insurance type reported to the COB contractor should be noted as qualified.
2. Part D Sponsors may compare the NCPDP SPAP ADAP BIN/PCN spreadsheet to their COB file to identify potential duplicate records. Part D Sponsors may send deletion records to the COB contractor for records with designation of supplemental insurance type as "Other" on the COB file where the RxBIN/RxPCN appears on the NCPDP spreadsheet.
3. Upon enrollment election beneficiaries may report COB coverage. If the COB information matches the RxBIN/RxPCN data found on the NCPDP SPAP ADAP BIN/PCN spreadsheet Part D Sponsors may opt to omit these records from their enrollment record, and should ensure that they are not reported with a supplemental insurance type other than 'qualified' to the COB Contractor.

Note: Supplemental payers should assign a unique RxBIN/RxPCN combination to their Medicare eligible population to ensure the efficiency of the recommendations above.

The NCPDP SPAP/ADAP list is an Excel file and is located under the link of **SPAP ADAP BIN PCN** link at http://ncdpd.org/resources_spap.aspx.

The Information Reporting Problems Task Group and CMS have also collectively worked together in industry efforts to identify the deletion of COB records from the COB Contractor data file for beneficiary submitted SPAP or ADAP coverage. This coverage was found to be duplicative and, often, incomplete, in comparison with the records submitted to the COB Contractor by the SPAP or the ADAP. CMS has helped to delete over 195,000 records. To this end, the deleted records have now ensured a cleaner match process and more efficient pairing of supplemental coverage information by the Part D processors. In addition, CMS has helped to make the SPAP and ADAP responsible for their data transmitted to the COB Contractor. CMS no longer permits updates of SPAP or ADAP data by any entity other than the SPAP or ADAP, itself. This lock-down of supplemental coverage data helps ensure that data is in sync with the SPAP or ADAP entity.

6.5 SUPPLEMENTAL PAYER HAS INCORRECT CMS PART D SPONSOR OF RECORD

Problem Statement: The SPAP or ADAP response file contains the Part D eligibility information for each Part D beneficiary. Periodically the Part D contract number and PBP on the file do not contain the current Part D Sponsor of record. This can occur when Part D beneficiaries have been issued new HICNs and crosswalk files from the old and new HICNs are not accurate within CMS systems or within the COB Contractor's system.

Recommendation: The SPAP or ADAP can identify these situations by receiving files of eligible beneficiaries from the Part D Sponsor that provides the benefit coverage. The file received from the Part D Sponsor can be compared to the SPAP or ADAPs response file from CMS. If the Part D Sponsor of record on the SPAP/ADAP response file does not match the Part D Sponsor's file of eligible beneficiaries, the SPAP or ADAP should contact the COB Contractor. If Part D Sponsors do not provide files of their eligible beneficiaries to SPAPs or ADAPs, the SPAP or ADAP can report discrepancies to the COB Contractor if reported by the beneficiary.

6.6 *RxBIN SHOULD BE DEFINED AS SIX POSITION NUMERIC FIELD*

Problem Statement: The RxBIN is defined as six digits numeric, where all six digits are significant. In some file exchanges, the RxBIN is being truncated or leading zeros are being stripped from the records. The identification of this field in any data exchange as an alpha field or a character field in a file layout may result in non-matched records with Part D Sponsors. The data in the field referred to as RxBIN in data exchanges and on the prescription ID card is the IIN issued by the American National Standards Institute (ANSI) or the BIN issued by the NCPDP.

Recommendation: The RxBIN is six digits and all digits must be treated as significant. Plans or processors should refer to the effective usage of 4Rx data in the following NCPDP **Recommendations for Effective 4Rx Usage in Medicare Part D Processing** document at: http://www.ncdp.org/news_hipaa_trans_current.aspx

6.7 *RECOMMENDED ELECTRONIC (ON-LINE) COB PROCESS AS DEFINED IN THIS WHITE PAPER IS NOT FOLLOWED BY THE SUPPLEMENTAL PAYER*

Problem Statement: To ensure that claims payments made by Qualified Supplemental payers count towards TrOOP for Medicare beneficiaries, supplemental payers must transmit electronic eligibility data to CMS on a monthly basis as per the CMS Data Sharing Agreement. CMS requires that Part D Sponsors coordinate benefits with supplemental payers that adhere to the agreement and transmit eligibility data to CMS. If claims are processed by a supplemental payer that does not use the recommended on-line COB process, the N transaction is either not created, or may not be posted by the Part D Sponsor. As explained in this white paper in detail above, the beneficiary's TrOOP balances can be incorrect and supplemental payers will not be included in COB activities.

Examples that illustrate situations where the on-line processing and the electronic COB process are not followed include:

- The supplemental payer does not send eligibility files to the COB Contractor, or does not follow the electronic eligibility file submission process as defined by CMS in the Data Sharing Agreement.
- The supplemental payer has a direct connection to a pharmacy. In this situation, the pharmacy does not use a switch to submit their claims to the supplemental payer. Only claims that are transmitted electronically through a switch can route supplemental payments (via an N transaction) to be posted by the Part D sponsor.
- The supplemental payer does not process claims in real-time or batch, and does not have a processor that performs these functions. Only online electronic claims can be routed to the CMS Transaction Facilitator.
- The Supplemental Payer does not require the National Provider ID number for claims adjudication. Allowing other pharmacy provider IDs such as the Medicaid number is not consistent with Medicare's requirements to use the NPI. The inconsistent rules between the payers can prevent Part D sponsors or the CMS Transaction Facilitator to match supplemental claims data to the corresponding Part D claims data to create the N transaction.

Recommendation: If any of the above situations are encountered, the supplemental payer must use the exception process to correct the posting of their payments by transmitting TrOOP Batch Transactions

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as outlined in section *“Transaction Facilitator “N” Creation and Transmission of Supplemental Claim Information to the Part D Sponsor – Batch”*. Following this process ensures that the Part D Sponsor receives the N transaction from the Part D Transaction Facilitator. Otherwise, the Part D Sponsor is unaware that the supplemental payer has covered a portion of the beneficiary’s cost share. This data is also publicly available on the NCPDP website at http://ncdpd.org/resources_spap.aspx under the section labeled “Batch N Transaction Request File Format.”

7. APPENDIX A. CMS FILE DEFINITIONS

7.1 *INDIVIDUALS AUTHORIZED ACCESS TO THE CMS COMPUTER SERVICES (IACS)*

IACS is the CMS enterprise Identity Management and Authentication system which implements the security requirements of federal legislation, Federal Standards, and CMS policy. The IACS mission is to provide secure, high quality identity management and authentication services to protect CMS systems and data. CMS uses IACS to allow individuals to apply for and obtain login credentials in the form of a User ID and a password. In addition, IACS is the tool where individuals apply for and receive approval to the required CMS systems.

7.2 *MEDICARE ADVANTAGE AND PRESCRIPTION DRUG (MARx) SYSTEM*

MARx supports the beneficiary enrollment and disenrollment as well as premium, and payment functions for Medicare beneficiaries.

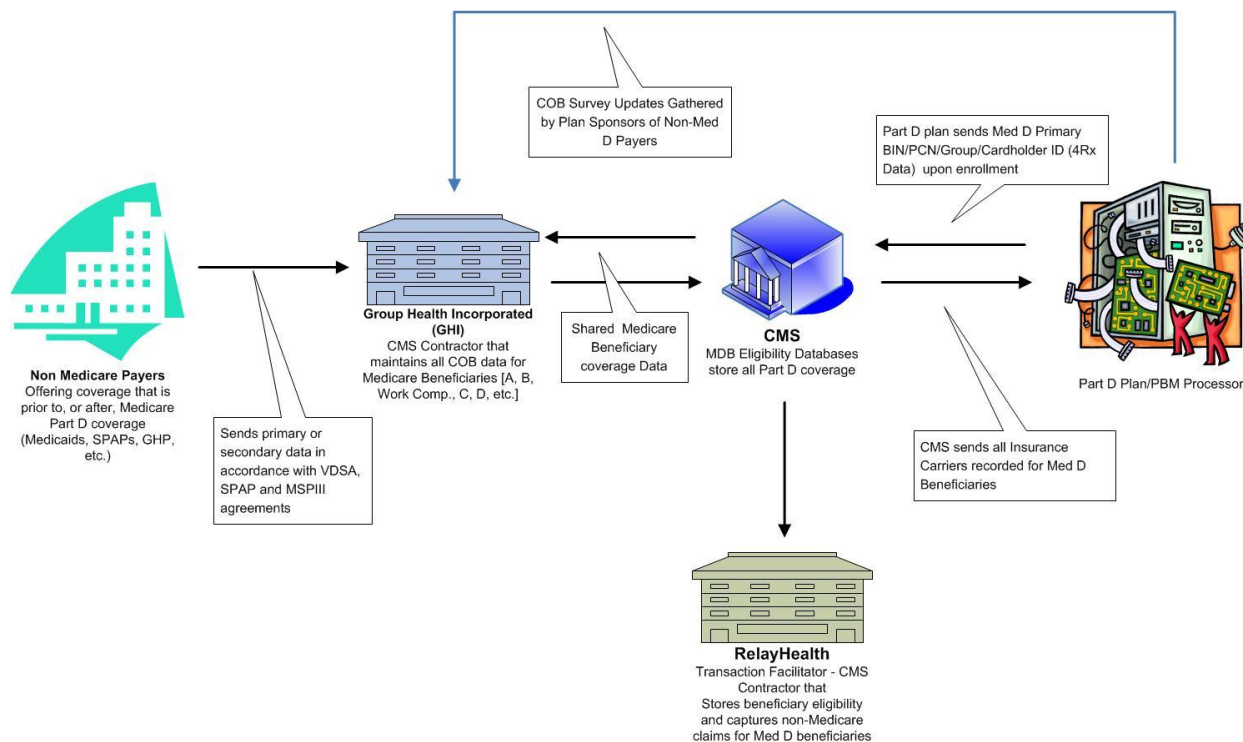
7.3 *MEDICARE BENEFICIARY DATABASE SUITE OF SYSTEMS (MBDSS)*

The Medicare Beneficiary Database Suite of Systems (MBDSS) is a single, enterprise-wide source for Medicare beneficiary data. The Medicare Beneficiary Database (MBD) is a centralized database that is able to communicate with other systems. The MBDSS provides full support for the wide array of benefit plans and beneficiary choices. The beneficiary information contained in the MBD is used to support managed care enrollments and payments to Medicare Advantage (MA) Plans.

The MBDSS supports the Part D Prescription Drug Benefit. It receives data from the Social Security Administration (SSA), the States, and nine external Common Working File (CWF) host sites. It also receives premium, eligibility, enrollment, and primary and supplemental payer information from various internal systems. This information enables CMS to process Medicare Part D enrollments, calculate State Phase Down amounts, and provide information to support claims processing, while providing needed information back to the SSA and the Railroad Retirement Board (RRB).

8. APPENDIX B. BUILDING ELIGIBILITY HISTORY FOR MEDICARE BENEFICIARIES DIAGRAM

Building Eligibility History for Medicare Beneficiaries



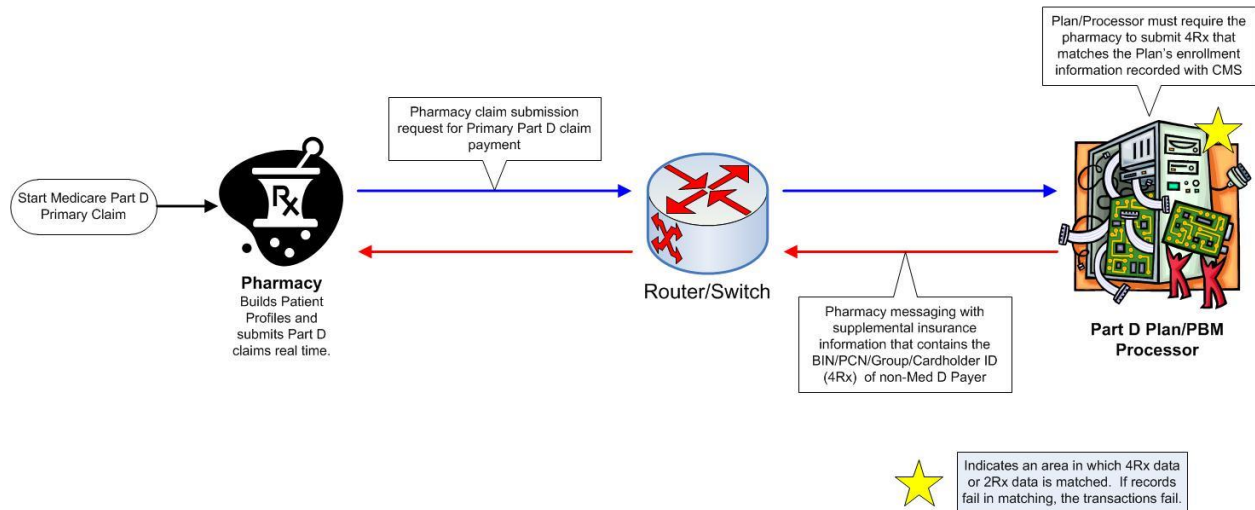
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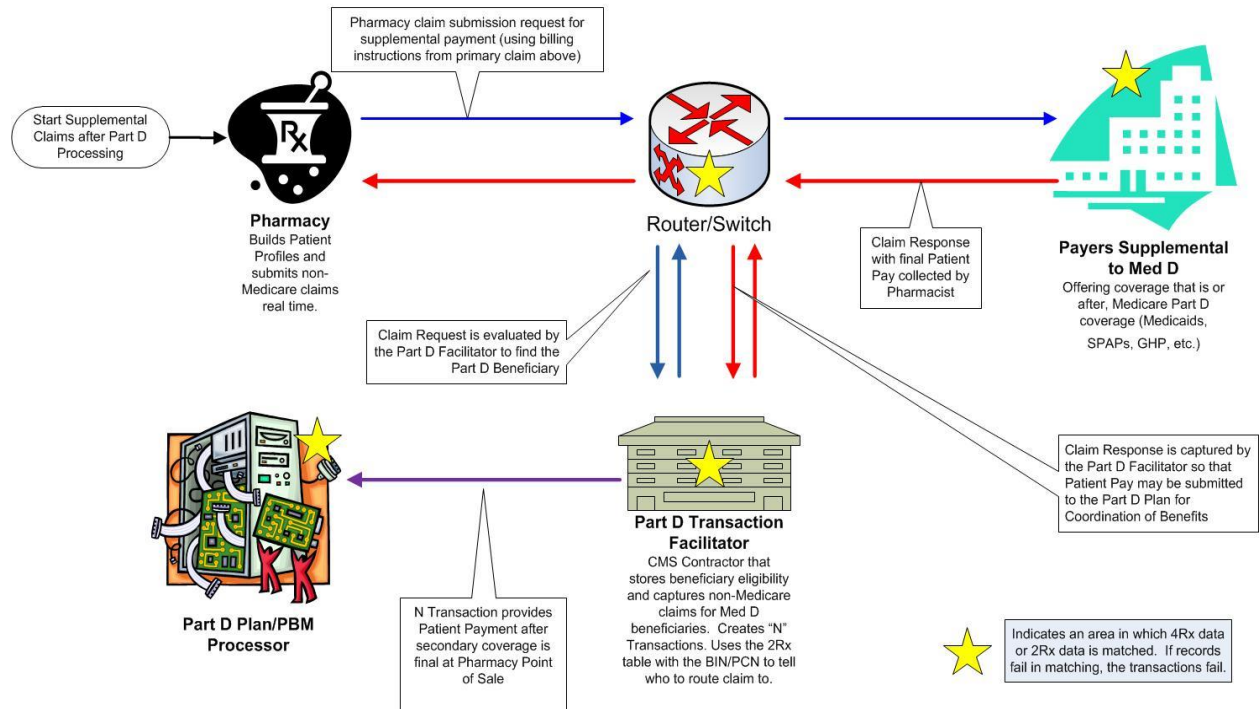
9. APPENDIX C. MEDICARE PART D PRIMARY CLAIM PROCESSING DIAGRAM

Part D Claim Processing Flow for Coordination of Benefits for Medicare Part D
(Part D Plan is the Payer)



10. APPENDIX D. SUPPLEMENTAL CLAIM PROCESSING FLOW FOR COORDINATION OF BENEFITS FOR MEDICARE PART D DIAGRAM

Supplemental Claim Processing Flow for Coordination of Benefits for Medicare Part D
(includes N transaction processing)

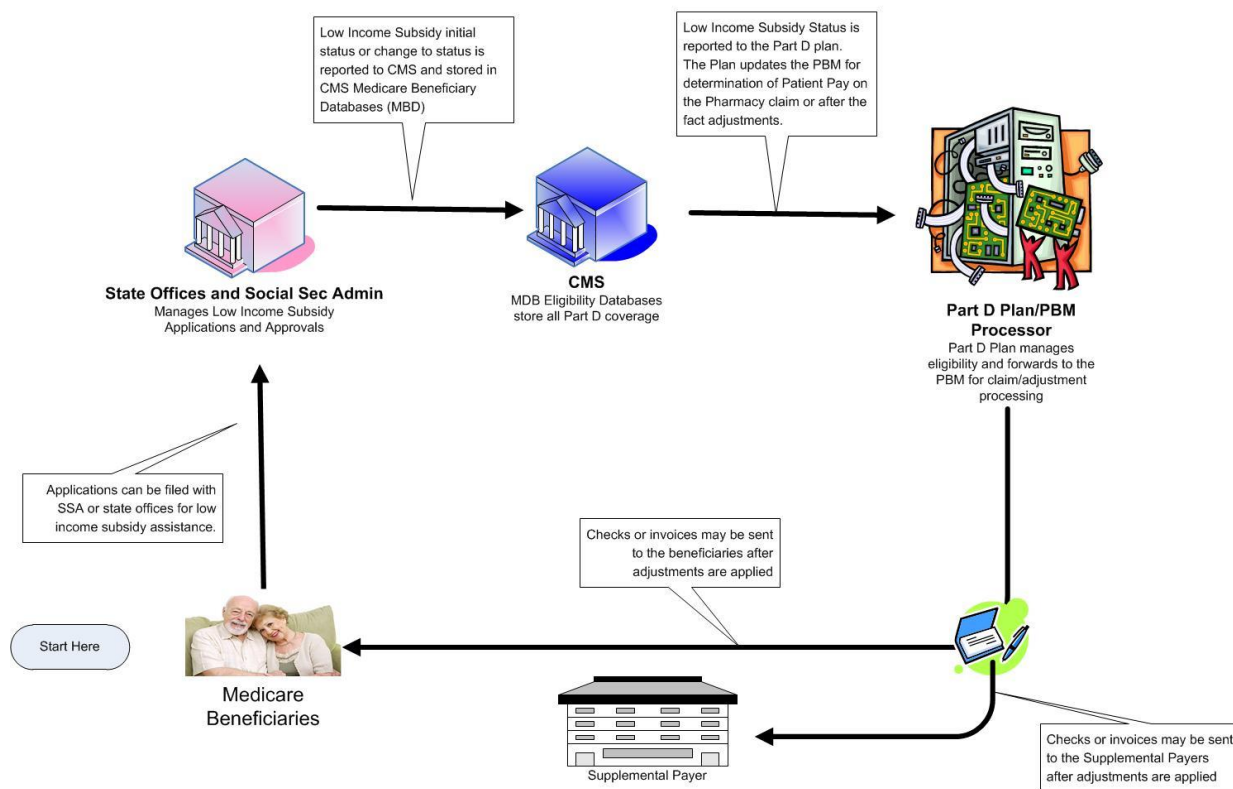


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11. APPENDIX E. RETROACTIVE LOW INCOME SUBSIDY ADJUSTMENTS DIAGRAM

Retroactive Low Income Subsidy Adjustments



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12. APPENDIX F. SPAP ELIGIBILITY FILE

As of 2012, 24 states have “qualified” State Pharmaceutical Assistance Program (SPAP) with SPAP agreements on file with CMS. SPAPs are always payers of last resort and always pay after Medicare Part D has been billed, first. The “qualified” status indicates that the SPAP’s payments are accounted towards their beneficiary’s TrOOP. SPAPs must obtain a unique, TrOOP-specific RxBIN/RxPCN to code for coverage that is supplemental to Medicare Part D. This unique coding will assure that a copy of the supplemental paid claim is captured by the Transaction Facilitation Contractor as the claims data moves through the health care billing and reimbursement EDI networks. “TrOOP Facilitation” RxBIN(s) and RxPCN(s) are required, and must be separate and distinct from the SPAP’s standard BIN(s) and PCN(s).

More information regarding SPAP requirements can be found at the CMS web site at:

<https://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/Downloads/SPAP-DSA.pdf>

States must submit SPAP files monthly containing the full list of beneficiaries. The file contains the typical identification fields of SSN, HICN, Surname, First Initial, DOB, Gender, as well as the following:

- Effective Date
- Termination Date
- RxID
- RxGroup
- RxPCN (Part D specific)
- RxBIN (Part D Specific)
- SPAP assigned Document Control Number (DCN)
 - DCN is a tracking number assigned by the data reporter to enable that reporter to more easily track files it is sending and receiving. DCN's aren't actively used by the COB Contractor or CMS – they are passed back unchanged to the sender.
- Coverage Type Indicator of “U” = “Network” (Electronic or POS benefit) or “V” (other type of benefit)
- Insurance Type Indicator of “Q” = “Qualified SPAP”. Other Insurance Type indicators are allowed:
 - N: Non-qualified State Program
 - O: Other
 - P: PAP
 - R: Charity
 - S: ADAP

CMS sends a response file containing the fields on the state's submission file plus additional fields containing the beneficiary's Part D enrollment and a Low Income Subsidy (LIS) indicator. The file layout can be found at: <https://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/Downloads/SPAP-DSA.pdf>

13. APPENDIX G. ADAP ELIGIBILITY FILE

As of 2012, 52 ADAP programs are qualified to have their payments count towards TrOOP (but only 32 have the necessary data sharing agreements in place with CMS). ADAPs are always payers of last resort and always pay after Medicare Part D has been billed, first. ADAPs must obtain a unique, TrOOP-specific RxBIN/RxPCN to code for coverage that is supplemental to Medicare Part D. This unique coding will assure that a copy of the supplemental paid claim is captured by the Transaction Facilitation Contractor as the claims data moves through the health care billing and reimbursement EDI networks. "TrOOP Facilitation" RxBIN(s) and RxPCN(s) are required, and must be separate and distinct from the ADAP's standard BIN(s) and PCN(s).

More information regarding ADAP requirements can be found at the CMS website at: <http://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/Downloads/ADAP-Specific-DSA-October-1-2012.pdf>

States submit ADAP files monthly containing the full list of beneficiaries. The file contains the typical identification fields of SSN, HICN, Surname, First Initial, DOB, Gender, as well as the following:

- Effective Date
- Termination Date
- RxID
- RxGroup
- RxPCN (Part D specific)
- RxBIN (Part D Specific)
- SPAP assigned DCN
- Coverage Type Indicator of "U" = "Network" (Electronic or POS benefit) or "V" (other type of benefit)
- Insurance Type Indicator of "S" = "Qualified ADAP". Other Insurance Type indicators are allowed:
 - N: Non-qualified State Program
 - O: Other
 - P: PAP
 - R: Charity
 - S: ADAP

CMS sends a response file containing the fields on the state's submission file plus additional fields containing the beneficiary's Part D enrollment and a Low Income Subsidy (LIS) indicator. The file layout can be found at: <http://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/Downloads/ADAP-Specific-DSA-October-1-2012.pdf>

14. APPENDIX H. MATCHING LOGIC PROVIDED BY TRANSACTION FACILITATOR

Using the supplemental claims transaction, an Information Reporting transaction (Nx) is generated when a matched record is found in the CMS data that is passed to the Transaction Facilitator. The Transaction Facilitator will only generate an Information Reporting transaction if the supplemental processor's RxBIN and RxPCN can be found on the SPAP ADAP BIN/PCN spreadsheet maintained by NCPDP, or if ten or more beneficiaries have claims transactions. In the case where ten or more beneficiaries have claims transactions, a table entry for the RxBIN/RxPCN will be inserted by the Transaction Facilitator and the data will be passed to Part D for consideration of the supplemental transactions.

The scenarios are compared in the order shown.

B Claim	CMS Database	Example	
Scenario 1: If more than one beneficiary is found, go to Scenario 3			
BIN	RxBIN	123456	123456
PCN	RxPCN	ABCD	ABCD
Cardholder ID	RxID - Any of SSN, HICN, RRB#	987654321	987654321
Scenario 2: If no HICN found, then quit			
BIN	RxBIN	123456	123456
Blank PCN	Blank RxPCN		
Cardholder ID	RxID - Any of SSN, HICN, RRB#	987654321	987654321
Scenario 3: If not HICN found, go to Scenario 4. If more than one HICN found, then quit.			
BIN	RxBIN	123456	123456
Any PCN	RxPCN	ABCD	ABCD
Cardholder ID	RxID - Any of SSN, HICN, RRB#	987654321	987654321
Date of Birth	Date of Birth	1/1/1950	1/1/2950
Scenario 4			
BIN	RxBIN	123456	123456
Any PCN	Blank RxPCN	ABCD	
Cardholder ID	RxID - Any of SSN, HICN, RRB#	987654321	987654321
Date of Birth	Date of Birth	1/1/1950	1/1/2950

15. APPENDIX I. INFORMATION REPORTING TRANSACTION INFORMATION

15.1 N1 LAYOUT

This is the layout as used by the Transaction Facilitator. Details of the transaction, syntax, etc. must conform to the NCPDP **Telecommunication Standard Implementation Guide version D.0**. Implementers must reference this document for details.

REQUEST HEADER SEGMENT							
N Transaction Field ID	N Transaction Field Name	Source Transaction	Source Transaction Field ID	Source Transaction Field Name	Type	Max Bytes	Comments
101-A1	BIN NUMBER	N/A	N/A	N/A	N	6	Part D Sponsor RxBIN from CMS Eligibility File
102-A2	VERSION/RELEASE NUMBER	N/A	N/A	N/A	A/N	2	D0
103-A3	TRANSACTION CODE	N/A	N/A	N/A	A/N	2	N1, N2, N3
104-A4	PROCESSOR CONTROL NUMBER	N/A	N/A	N/A	A/N	10	Part D Sponsor RxPCN From CMS Eligibility File
109-A9	TRANSACTION COUNT	N/A	N/A	N/A	N	1	Always = 1
202-B2	SERVICE PROVIDER ID QUALIFIER	Supplemental Claim Request	202-B2	SERVICE PROVIDER ID QUALIFIER	A/N	2	Direct copy from Request Transaction
201-B1	SERVICE PROVIDER ID	Supplemental Claim Request	201-B1	SERVICE PROVIDER ID	A/N	15	Direct copy from Request Transaction
401-D1	DATE OF SERVICE	Supplemental Claim Request	401-D1	DATE OF SERVICE	N	8	Direct copy from Request Transaction
110-AK	SOFTWARE VENDOR/CERTIFICATION ID	N/A	N/A	N/A	A/N	10	"TROOP " or "TROOPBATCH" (TROOP if N was generated from real-time B, TROOPBATCH if generated from batch N or is a replayed transmission

INSURANCE SEGMENT (111-AM = 04)							
N Transaction Field ID	N Transaction Field Name	Source Transaction	Source Transaction Field ID	Source Transaction Field Name	Type	Max Bytes	Comments

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NCPDP Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process

INSURANCE SEGMENT (111-AM = 04)							
N Transaction Field ID	N Transaction Field Name	Source Transaction	Source Transaction Field ID	Source Transaction Field Name	Type	Max Bytes	Comments
302-C2	CARDHOLDER ID	Supplemental Claim Request	302-C2	CARDHOLDER ID	A/N	20	From CMS Eligibility File Part D Record if the Supplemental claim is a B1 or B3. If the Supplemental claim is a B2, it is not used by the transaction facilitator, however if it exists on the B2 it is directly copied to the N2.
312-CC	CARDHOLDER FIRST NAME	Claim Request	312-CC	CARDHOLDER FIRST NAME	A/N	12	Direct copy from Request Transaction. Sent on N1 and N3 only.
313-CD	CARDHOLDER LAST NAME	Supplemental Claim Request	313-CD	CARDHOLDER LAST NAME	A/N	15	Direct copy from Request Transaction. Sent on N1 and N3 only.
301-C1	GROUP ID	Supplemental Claim Request	301-C1	GROUP ID	A/N	15	Direct copy from Request Transaction. This field is not used by the Transaction Facilitator when attempting to find an eligibility match.
990-MG	OTHER PAYER BANK IDENTIFICATION NUMBER	Supplemental Claim Request	101-A1	BIN NUMBER	N	6	The BIN from the supplemental transaction is used and this matches the OHI BIN in the CMS Eligibility File. This field will always be sent because the supplemental transmission must have an RxBIN.
991-MH	OTHER PAYER PROCESSOR CONTROL NUMBER	Supplemental Claim Request	104-A4	PROCESSOR CONTROL NUMBER	A/N	10	The PCN from the supplemental transaction is used; however, it may not match the RxPCN in the CMS Eligibility File due to wildcarding. This field will always be sent because the supplemental transmission must have a RxPCN.
356-NU	OTHER PAYER CARDHOLDER ID	Supplemental Claim Request	302-C2	CARDHOLDER ID	A/N	20	The Cardholder ID from the supplemental transaction is used and this matches the OHI RxID. For N2s, if the source transaction doesn't contain Cardholder ID none will be sent.
992-MJ	OTHER PAYER GROUP ID	Supplemental Claim Request	301-C1	GROUP ID	A/N	15	Direct copy from Request. If no GroupID exists on source transaction, none will be sent on N transaction.

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NCPDP Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process

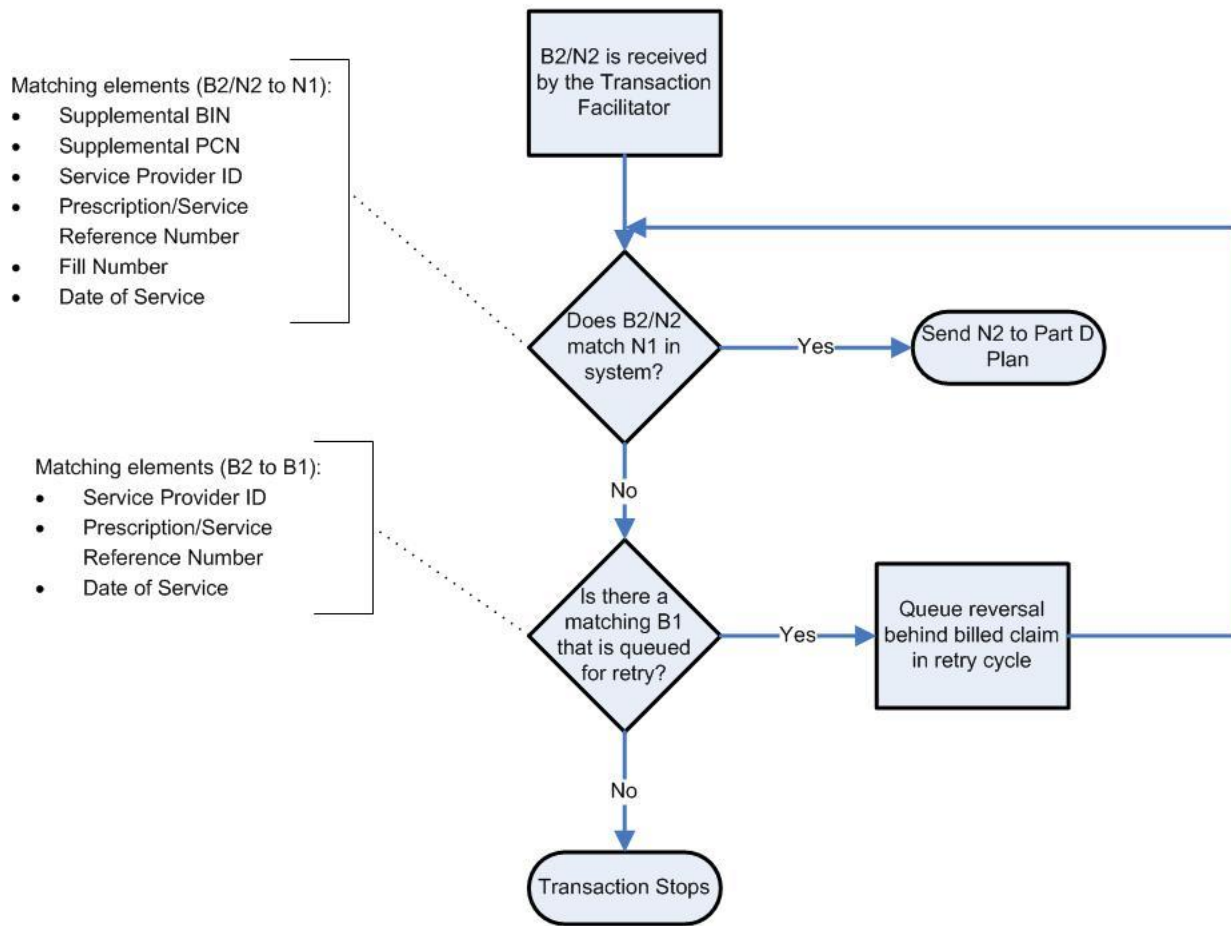
CLAIM SEGMENT (111-AM=07)							
N Transaction Field ID	N Transaction Field Name	Source Transaction	Source Transaction Field ID	Source Transaction Field Name	Type	Max Bytes	Comments
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	Supplemental Claim Request	455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	A/N	1	Direct copy from Request Transaction, blank field sent if source field not available.
402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	Supplemental Claim Request	402-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	N	12	Direct copy from Request Transaction, blank field sent if source field not available.
436-E1	PRODUCT/SERVICE ID QUALIFIER	Supplemental Claim Request	436-E1	PRODUCT/SERVICE ID QUALIFIER	A/N	2	Direct copy from Request Transaction, blank field sent if source field not available.
407-D7	PRODUCT/SERVICE ID	Supplemental Claim Request	407-D7	PRODUCT/SERVICE ID	A/N	19	Direct copy from Request Transaction, blank field sent if source field not available.
442-E7	QUANTITY DISPENSED	Supplemental Claim Request	442-E7	QUANTITY DISPENSED	9(7)v999	10	Direct copy from Request Transaction. Sent on N1 and N3.
403-D3	FILL NUMBER	Supplemental Claim Request	403-D3	FILL NUMBER	N	2	Direct copy from Request Transaction.
405-D5	DAYS SUPPLY	Supplemental Claim Request	405-D5	DAYS SUPPLY	N	3	Direct copy from Request Transaction. Sent on N1 and N3.
880-K5	TRANSACTION REFERENCE NUMBER	N/A	N/A	N/A	A/N	10	Generated by Transaction Facilitator system generated (N2 matches N1/3).

PRICING SEGMENT (111-AM=11) Note: Pricing Segment is not sent if 433-DX not sent							
N Transaction Field ID	N Transaction Field Name	Source Transaction	Source Transaction Field ID	Source Transaction Field Name	Type	Max Bytes	Comments
433-DX	PATIENT PAID AMOUNT SUBMITTED	Supplemental Claim Response	505-F5	PATIENT PAY AMOUNT	s9(6)v99	8	This data is copied from the 505-F5 Supplemental Payer Response Transaction. When the source field is not available (such as for B2 and N2's), the segment and field is not sent.

Note: for fields listed as "Direct copy from Request Transaction", the field is not added to the generated N if source field is blank or missing.

15.2 MATCHING LOGIC FOR REVERSALS BY THE TRANSACTION FACILITATOR

Matching Logic for Reversals by the Transaction Facilitator



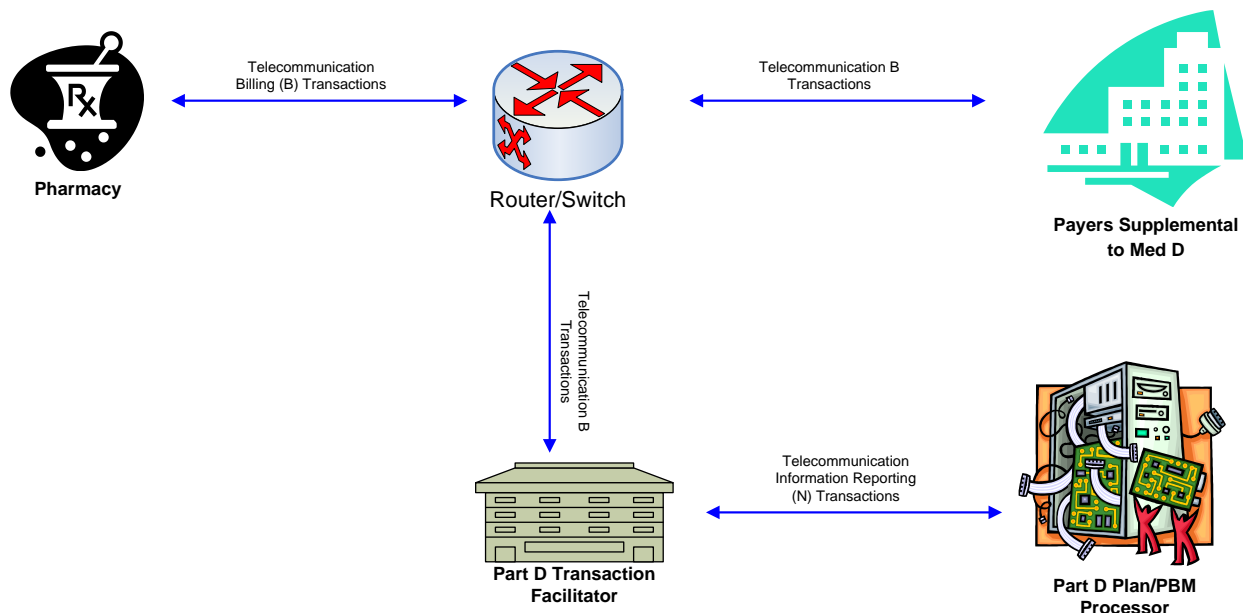
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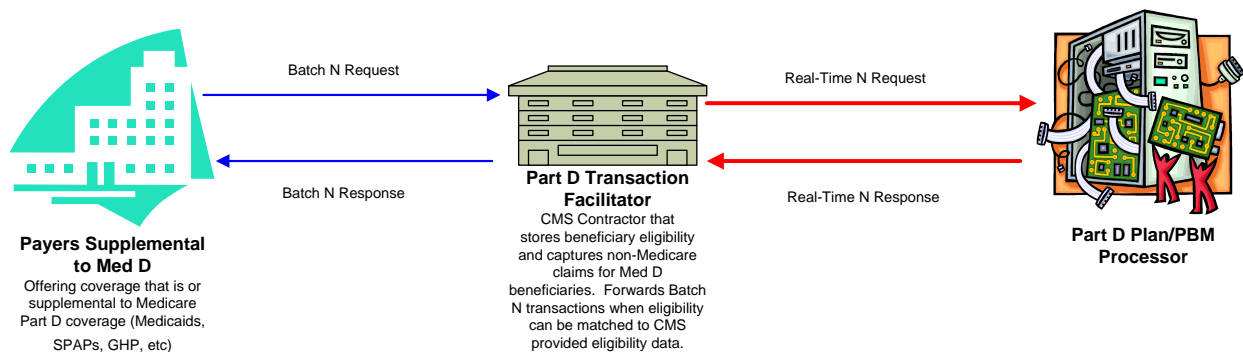
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16. APPENDIX J. INFORMATION REPORTING TRANSACTION FLOWS

N Transaction Flow from the Pharmacy to the Part D Sponsor through Real-Time Processing



N Transaction Flows from Supplemental Payers to the Part D Sponsor Through Batch N Processing



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17. APPENDIX K. HOW N TRANSACTIONS ARE APPLIED BY THE PART D SPONSOR

Part D Sponsors are required to manage TrOOP on behalf of the beneficiaries that are enrolled in their plan. Below is a summary of how COB information is used by Part D Sponsors, how they apply Information Reporting transactions and how PDEs are reported to CMS.

1. Part D Sponsors gather Other Health Information (OHI) from beneficiaries during COB survey processes and upon initial enrollment. Part D Sponsors are required to report updates to a beneficiary's OHI to the COB Contractor.
2. The COB Contractor gathers OHI information from various payers and provides a comprehensive file to Part D Sponsors to use in pharmacy messaging and to determine how Information Reporting transactions should be posted.
3. When a Part D Sponsor receives an Information Reporting transaction from the Transaction Facilitator, the Part D Sponsor finds the original paid claim in their systems. If not found, the Information Reporting transaction is rejected back to the Transaction Facilitator. If found, the Part D Sponsor computes the difference between the patient pay on the Information Reporting transaction and the patient liability (505-F5) on the primary Part D claim to determine how much the other payer contributed. The Part D Sponsor reports the dollars in one of two fields on the Prescription Drug Event file that is sent to CMS based on the supplemental payer's TrOOP eligibility status:
 - a. Other TrOOP Amount: This field indicates the dollar amount paid on behalf of the beneficiary by third party TrOOP eligible payers.
 - b. Patient Liability Reduction Due to Other Payer Amount (PLRO): This field is populated with the dollar amount paid by entities that reduce patient liability/cost, but do **not** count as TrOOP.
4. The Part D Sponsor uses the COB file provided by the COB Contractor to determine if the dollars paid by the supplemental payer should be TrOOP-able or not. Below is an example of how a Part D Sponsor applies an Information Reporting transaction and calculates the TrOOP or other payer amounts to be reported on the PDE to CMS.

Primary claim Paid by Part D Sponsor	
Beneficiary liability	\$26
Plan Paid Amount	\$82
Secondary uses copay only option (OCC=8) and pays 60% of copay- no COB segment is sent	
Beneficiary liability Amount from Primary	\$26
Beneficiary liability amount from Secondary	<u>\$15.60</u>
Final secondary plan liability	\$10.40
Information Reporting transaction calculation	
Part D beneficiary liability	\$26
Less other payer beneficiary liability	<u>\$10.40</u> Submitted on the N transaction
Amount attributed to other payer	\$15.60

If the other payer is qualified, the 15.60 does not affect TrOOP, however it is reported on the PDE as Other TrOOP.

If the other payer IS NOT qualified, the 15.60 reduces the beneficiary's TrOOP and is applied to PLRO.

Note: Combination of secondary beneficiary liability and amount attributed to other payer cannot exceed the Part D beneficiary liability, even if the supplemental plan contributed more. However, in this example it will never happen because the supplemental plan is paying a percentage of the primary beneficiary liability.

Secondary uses full calculation option with beneficiary coinsurance as a percentage of total paid	
Secondary prices claim at negotiated rate	\$102
Less other plan paid amount	-\$82
Plan liability before beneficiary liability reduction	\$20
Beneficiary liability of 15%	<u>\$3.50</u>
Final secondary plan liability	\$16.50
Information Reporting transaction calculation	
Part D beneficiary liability	\$26
Less other payer beneficiary liability	<u>\$3.50</u>
Submitted on the N transaction	
Amount attributed to other payer	\$22.50

If the other payer is qualified, the 22.50 does not affect TrOOP, however it is reported on the PDE as Other TrOOP.

If the other payer IS NOT qualified, the 22.50 reduces the beneficiary's TrOOP and is applied to PLRO.

Note: Combination of secondary beneficiary liability and amount attributed to other payer cannot exceed the Part D beneficiary liability, even if the supplemental plan contributed more.

References:

<http://www.cms.gov/Medicare/Coordination-of-Benefits/COBPartD/index.html?redirect=/COBPartD/>

<http://www.csscooperations.com/internet/cssc3.nsf/DocsCat/CSSC~CSSC%20Operations~Prescription%20Drug%20Event~Training~Prescription%20Drug%20Event~8LAP7A1257?open&navmenu=Prescription^Drug^Event>

[http://www.csscooperations.com/internet/Cssc.nsf/files/ReconciliationWorkbook.pdf/\\$File/ReconciliationWorkbook.pdf](http://www.csscooperations.com/internet/Cssc.nsf/files/ReconciliationWorkbook.pdf/$File/ReconciliationWorkbook.pdf)

TrOOP-eligible	Not TrOOP-eligible
<ul style="list-style-type: none"> Beneficiary Payments by family, friends, or other qualified entities or individuals on behalf of a beneficiary Charities and Qualified State Pharmaceutical Assistance Programs (SPAPs) and AIDS Drug Assistance Programs (ADAPs) Indian Health Service (IHS), an Indian tribe or tribal organization, or an urban Indian organization Low-income cost-sharing subsidy (LICS) Medicaid payments in lieu of LICS for beneficiaries residing in U.S. territories¹ 	<ul style="list-style-type: none"> Workers' Compensation Governmental programs (VA, Black Lung, TRICARE, other) Automobile/No-fault/Liability Insurances Group health plans
¹ Medicaid cost-sharing subsidies for residents of the U.S. territories that are funded under §1860D-42(a) of the Act count towards TrOOP. In all other circumstances, Medicaid is not a TrOOP eligible insurance.	

18. APPENDIX L. RETRY OF N TRANSACTIONS BY THE TRANSACTION FACILITATOR

There are multiple scenarios where the industry has determined that the failure to generate an Information Reporting (N) transaction or the failure to process an N transaction by a Part D Sponsor warrant additional attempts to find a matched record. These scenarios are outlined below.

Scenario #1- Communication-related failures (Reject Code (511-FB) “90 “ series).

1. N transaction rejects with a Reject Code between “90 and “99 “ are generally related to host-processing type errors where the processor is unable to handle the N transaction.
2. Due to the nature of these errors they are retried roughly every 15 minutes up to 48 hours. If the N transaction has not been accepted/processed during the 48 hour period, the Transaction Facilitator ceases transmission on these transactions and they are identified on the daily exception report. The Part D Sponsor/Processor that rejected the N transaction will have to submit a request to the Transaction Facilitator to have the transaction retried.
3. A **retry** is defined as an additional attempt to transmit the exact same information that was previously transmitted and rejected by a processor.

Scenario #2: N Transaction rejections due to 4Rx data mismatching related to the Part D 4Rx data on the N transaction.

1. As of 07/01/2012 CMS will enforce compliance actions on the requirement that all Part D Sponsors have RxBIN or RxBIN/RxPCN combinations that are solely used for Part D. Additionally all submitted 4Rx data on any transaction (B, N, FIR) must match the 4Rx data that was submitted to CMS for the Part D beneficiary. In order to ensure that N transactions that are rejected during the transition to the unique Part D 4Rx data or during the yearly renewal/new plan year period, the industry recommended that any N transactions rejected with the following NCPDP Reject Codes will be queued for a follow-up:
 - “01 “ M/I BIN
 - “04 “ M/I PCN
 - “06 “ M/I Group
 - “07 “ M/I Cardholder ID
 - “52 “ Non-match cardholder ID
 - “51 “Non-match group
 - Additional codes as determined by NCPDP
2. A **follow-up** is defined as using the original B transaction and rerunning it through the N conversion process using current Part D 4Rx data that is on file at the time of the follow-up (this may not look like any prior N that was generated if the eligibility has changed since prior follow-ups or the original transmission occurred).
3. The industry defined intervals for the N generation follow-up is:
 - Once a week for four weeks
 - Then once a month for 2 months

Scenario #3: SPAP and ADAPs submit eligibility every 30 days to CMS. As a result, there may be Part D claims where a supplemental payer has paid a portion of the claim that fail to generate a match because of the timing of the eligibility loads. In order to generate an N transaction from the paid claims, eligibility must be received, matched, and loaded by CMS, the Transaction Facilitator and the Part D Sponsors.

1. There are claims billing transactions that fail to generate an N transaction due to the ability of the Transaction Facilitator to match the 4Rx data on the claim to the 4Rx data submitted by the supplemental payer to CMS. Since SPAP/ADAPs are only allowed to submit a file monthly to the COB Contractor, delays in eligibility are inherent in the system. A follow-up process has been created for situations when the Transaction Facilitator cannot find matching supplemental 4Rx data found for any SPAP/ADAP RxBIN/RxPCN.
2. NCPDP created a process that allows SPAPs and ADAPs to notify the industry of their qualified status using their RxBIN or RxBIN/RxPCN. (See http://www.ncpdp.org/resources_spap.aspx).

3. The industry approved an automated process to follow-up the records that previously failed. This process attempts to match the 4Rx data on the supplemental claim to the 4Rx data on file at the time of the follow-up. The Transaction Facilitator has implemented the follow-up process for qualified SPAP/ADAPs and utilizes RxBIN/RxPCN derived from the NCPDP list. If the RxBIN/RxPCN is on the qualified SPAP/ADAP list and the N could not be generated due to the following reasons, the supplemental claim will be queue to follow-up based on the industry defined interval for N generation follow-up listed below:
 - Supplemental plan not found (includes B2 where matching N1/N3 was not found)
 - Found more than one patient with same supplemental plan (and couldn't narrow down by Date of Birth)
 - Found Part D Sponsor but Part D RxBIN is blank
 - No Part D Sponsor active for given Date of Service
4. Billing transactions with the above rejects will be followed up. At the time of follow-up (the new attempt to find a matched record), the Information Reporting (N) process will query using the Supplemental 4Rx data and Part D 4Rx data to determine if a matched record for the 4Rx data now occurs for the coverage period of the transaction date of service. If a matched record now is found, the follow-up N transaction will be updated to reflect the current Part D and supplemental payer 4Rx data, and sent to the Part D Sponsor.
5. The industry defined intervals for the N generation follow-up is:
 - Once a week for four weeks
 - Then once a month for 2 months