National Council for Prescription Drug Programs
NCPDP

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This document was created by an NCPDP Task Group.

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NCPDP MEDICARE PART D NON-PLAN OF RECORD

Version1.Ø

This document provides guidance for Medicare Part D Plans on how to transfer TrOOP and Gross Drug Spend accumulators when claims have been paid by a non-plan of record.

December 2Ø13

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NCPDP MEDICARE PART D NON-PLAN OF RECORD WHITE PAPER

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Published by:
National Council for Prescription Drug Programs

Publication History:
Version 1.Ø December 2Ø13
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1. PURPOSE

A "non-plan of record" is a Part D Sponsor ("Part D plan") that paid covered Part D drug claims for a Medicare beneficiary for whom the Part D plan is determined to not have had a valid and effective Part D enrollment period in the Centers for Medicare & Medicaid Services (CMS) system that covers the claims' dates of service. Determination of valid and effective enrollment can and does sometimes change after the actual pharmacy billing and plan payment to the pharmacy. This may occur in situations such as:

- When the beneficiary terminates Part D enrollment and the Part D plan fails to update their enrollment systems timely or at all,
- When the Part D plan submits a Part D enrollment transaction that was processed by CMS and is then audited off due to CMS' receipt of a subsequent valid Part D enrollment transaction for the same effective date,
- When the Part D plan submits a Part D enrollment transaction that was not accepted by CMS and, therefore, is not in the CMS system.
- When a retroactive change in enrollment occurs causing the Part D plan of record to become a non-plan of record.

Although rare, there might be multiple non-plans of record for a beneficiary during a coverage year, even for the same month.

This document is intended to identify the scenarios and address how to meet the True Out Of Pocket (TrOOP) balance transfer requirements.

1.1 CMS OVERVIEW

CMS' Part D Sponsor implementation guidance on automated TrOOP balance transfer, included as Appendix C to the COB chapter of the Medicare Prescription Drug Benefit manual, addresses the issue of non-plans of record in a section entitled, "Inclusion of non-plans of record." The guidance notes that TrOOP-related data must also be transferred between Part D plans when a Part D plan other than the plan of record (i.e., a non-plan of record) paid for covered Part D drug costs as a primary payer and subsequently becomes aware that the beneficiary is enrolled in another Part D plan. This may occur if this other plan's Part D enrollment was processed and then retroactively terminated due to CMS' receipt of a subsequent valid Part D enrollment transaction for the same effective date, or if the Part D enrollment in this other plan was not accepted by CMS and, therefore, is not in the CMS system. Most retroactively terminated Part D enrollments will be identifiable by the Transaction Facilitator. If more than one enrollment record was retroactively terminated on the same date, only the latest record terminated will be reflected on the CMS Eligibility File sent to the Transaction Facilitator.

For the TrOOP data to be transferred for the affected beneficiary when the Transaction Facilitator is unable to identify the existence of a non-plan of record, the non-plan of record must contact the Transaction Facilitator and request inclusion in the Financial Information Reporting (FIR) process. To include these non-plans of record in the FIR process, the Transaction Facilitator must create a "proxy" Part D enrollment record identifying the Part D plan, rather than CMS, as the source of the information, the contact person providing the information and the date of contact. The Transaction Facilitator will include the non-plan of record in the FIR transaction stream preceding the actual plan of record for the month(s) the non-plan of record paid Part D claims.

Section 50.14.1 of the COB chapter, addresses the process of Part D plan-to-plan (P2P) reconciliation during transition periods. This section noted that, due to lags associated with the Part D enrollment process and information systems updates, the Part D plan from which a beneficiary has transferred can make payment for covered prescription drug costs incurred after the effective date of the beneficiary's Part D enrollment in the new Part D plan of record. This process enables CMS to process Prescription Drug Event (PDE) data in these P2P transition situations and allow for financial reconciliation between the affected Part D plans. The process'

protects Part D plans from exposure to costs outside the initial formulary transition period by using a 30-day P2P transition period.

Note: This process does not replace automated TrOOP balance transfer because it does not involve the reporting of monthly accumulators. Part D plans will still need to report accumulated balances via the automated TrOOP balance process.

1.1.1 DRUG DATABASE PROCESSING SYSTEM (DDPS) TRANSACTION & VALIDATION EDITS

The following table lists Prescription Drug Events (PDE) errors that are most commonly associated with eligibility edits. These may occur when the Part D plan or the plan's processor's eligibility information differs from the information CMS has in their system. For the rest of this document, please reference this table for information on the failure outcome or the Error Number. Note the industry also refers to Error Numbers as Edits. In this document, the term Error Number is used.

Source: CMS

Error Number	Edit Category	Data Element to be Edited	Message to be Reported	Failure Outcome (Reject, Informational, or Update)
705	Elig	Date of Service (DOS)	The Beneficiary must be enrolled in Part D on the DOS.	Reject
706	Elig	Date of Service (DOS)	This DOS does not fall in a valid P2P period. The Beneficiary must be enrolled in this Contract on the DOS.	Reject
708	Elig	Date of Service (DOS) Contract Drug Coverage Status Code	Submitting Contract differs from contract of record; this PDE is subject to plan-to-plan reconciliation.	Informational
709	Elig	Date of Service (DOS) Contract Drug Coverage Status Code	Even though the Submitting Contract does not equal the contract of record, this PDE is not subject to plan-to-plan reconciliation. PDEs with drug coverage status of 'E' or 'O' are not eligible for plan-to-plan reconciliation	Informational
712	Elig	Date of Service (DOS), Submitting Contract	Submitting Contract was not prior Contract of Record for this P2P period.	Informational

1.1.2 PLAN TO PLAN (P2P) PROCESS

Throughout the year, Part D plans may receive the following P2P reports monthly:

1. P2P Accounting Report 40; File ID 40COVCCYY###
2. P2P Receivable Report 41; File ID 41COV
3. P2P Part D Payment Reconciliation Report 42: File ID 42COV
4. P2P Payable Report 43: File ID 43COV

For the purposes of this document these reports are collectively referred to as "P2P Reports." These reports show payables and receivables, the full amount of which Part D plans are responsible for reconciling with one another. Prior to the Annual Part D Payment Reconciliation, CMS updates previously accepted PDEs for any changes in Contract and/or PBP of Record. The monthly reports for the processing month in which CMS performs the Contract/PBP Update will show any new payables and receivables that result from the Contract/PBP Update. These amounts must be reconciled in full. CMS conducts this process prior to the Part D Payment Reconciliation to ensure that the Contract of Record has paid all of the claims for each beneficiary enrolled in their Contract.

A P2P situation will occur when:

1. The Part D plan is still plan of record for a portion of the plan year; and

2. For the period of time that the Part D plan has become the non-plan of record, a PDE is submitted with a Date of Service that is less than or equal to the later of either the Part D Effective Enrollment date plus 30 days or the CMS Process Date plus 30 days; and
3. The PDE with Error Number 708.

The P2P editing is based upon Date of Service not the date submitted; so, if an original PDE is submitted and received Error Numbers *708 and 712 in combination*, the adjustment PDE will also receive the Error Numbers of 708 and 712 assuming the enrollment information has not changed. The only exception to this rule is if the adjustment is submitted after the reconciliation cut-off date for the benefit year. After the reconciliation cut-off date, all P2P PDEs submitted for that particular benefit year will receive Error Number 706.

While CMS provides the P2P Reports, we are not recommending the use of these reports for the purposes of identifying beneficiaries who need to have their accumulators transferred. The P2P reports are only generated when the Part D plan is a plan of record for a portion of the plan year and also a non-plan of record for a time during the plan year. Additionally, the P2P process and reports do not address situations in which payments are made for Dates of Service (DOS) that are outside of the P2P process time frames specified above, or when the beneficiary has been completely audited off CMS' system. These scenarios result in Error Number 706; therefore, they are not included in the P2P Reports. Also not included are PDEs from the non-plan of record that have rejected for errors other than 706.

1.2 WHAT P2P REPORTS DO NOT COVER

For a Part D non-plan of record, Error Number 706 will be generated when:

- The Date Of Service is not less than or equal to the later of either the Part D Effective Enrollment date plus 30 days or the CMS Process Date plus 30 days; or
- The Enrollment Source Code is D (indicating a CMS Rollover); or
- The beneficiary's enrollment was completely audited off of CMS' system due to a retroactive termination, which resulted in the non-plan of record not being the beneficiary's plan of record for any time during the plan year. Because the beneficiary's coverage was audited off, there is no enrollment period to which the 30-day rule for P2P can be applied. Note, in this situation, MARx will not display any beneficiary information related to the audited off non-plan of record.

If the Date of Service occurs after the later of the two P2P dates, the Submitting Contract should not have the beneficiary in their enrollment database and should not have paid claims for this beneficiary. If the Enrollment Source Code is D, the beneficiary was part of the CMS annual Rollover process and must be enrolled in the Submitting Contract on the Date of Service. The Submitting Contract should evaluate all Error Numbers 706 received from CMS. CMS will also generate Error Number 712 if the Submitting Contract is not the Prior Contract of Record. The Submitting Contract is responsible for evaluating the informational Error Numbers (including 708). Part D plans should immediately investigate enrollment information when they begin to receive Error Number 708 as it can be an indicator that the plan's CMS enrollment data differs from the Part D plan. If a Part D plan investigates and updates their systems as soon as possible, P2P activity is minimized.

1.3 INCLUSION OF PART D NON-PLANS OF RECORD

TrOOP-related data must also be transferred between Part D plans when a Part D plan other than the plan of record (i.e., a non-plan of record) paid for covered Part D drug costs as a primary payer and subsequently becomes aware that the beneficiary is enrolled in another Part D plan.

This may occur if this other plan's Part D enrollment was processed and then retroactively terminated due to CMS' receipt of a subsequent valid Part D enrollment transaction for the same effective date, or if the Part D enrollment in this other Part D plan was not accepted by CMS and, therefore, is not in the CMS system.

For the TrOOP data to be transferred for the affected beneficiary when the Transaction Facilitator is unable to identify the existence of a non-plan of record, the non-plan of record must contact the Transaction Facilitator and request inclusion in the Financial Information Reporting (FIR) process. To include these non-plans of

record in the FIR process, the Transaction Facilitator must create a "proxy" Part D enrollment record identifying the Part D plan, rather than CMS, as the source of the information, the contact person providing the information and the date of contact. The Transaction Facilitator will include the non-plan of record in the FIR transaction stream preceding the actual Part D plan of record for the month(s) the non-plan of record paid Part D claims.

While CMS does not have record of the Part D enrollment in their system, the Health Insurance Claim Number (HICN) for the beneficiary is active in Part D; therefore, the PDE records will be accepted for the non-plan of record for purposes of Part D P2P reconciliation.

1.4 OBJECTIVE

The objective of this document is to identify situations in which a Part D plan has accumulated balances for a beneficiary; however the Part D plan is not the Part D plan of record. The intent of this document is to outline the processes necessary to ensure the accumulators are transferred by the non-plan of record through a FIR transaction. This document covers the following situations.

- A beneficiary was auto/facilitated enrolled and is subsequently disenrolled prior to the actual effective date. (If enrollment is available prior to the effective date, a FIR transaction will be triggered one day prior to the effective date.)
- The beneficiary was never approved in your Part D plan because CMS had accepted a Part enrollment in another Part D plan.
- CMS rejected the Part D enrollment and the beneficiary was never approved due to another Part D plan of record.
- A beneficiary was previously approved in your Part D plan but was retroactively terminated back to the original effective date.

In some cases, a FIR transaction is initiated when the beneficiary was retroactively terminated back to their original effective date but not always. Part D plans should monitor their non-plan of record beneficiaries' that have TrOOP and Gross Drug Spend accumulators and determine whether or not a FIR transaction has been generated and, if not, the Part D plan should submit a 'proxy add' to the Transaction Facilitator. See the examples in the next section.

2. DEFINITIONS

4Rx – RxBIN/RxPCN/RxGroup/RxID data elements. The 4Rx information must be the same on the member's ID card, in the CMS Medicare Beneficiary Database, Part D plan systems, PBMs, the Part D Transaction Facilitator and other CMS contracted entities. *CMS guidance in Chapter 5 of the Medicare Prescription Drug Benefit Manual in section 90.1 entitled, "Unique Benefit Identification Number (BIN)/Processor Control Number (PCN) Provisions" states:*

> *For Part D claims with a dispensing date of January 1, 2012 and later, and submitted in, National Council for Prescription Drug Programs (NCPDP) [Telecommunication] version D.0 format, a Part D Sponsor must assign and exclusively use a unique:*
>
> - *Part D cardholder identification number (RxID) for each Medicare Part D enrollee to clearly identify Medicare Part D beneficiaries (other fields such as person code may not be used to differentiate enrollees), and*
> - *Part D BIN or RxBIN and Part D processor control number (RxPCN) combination in its Medicare Part D line of business, unless non-exclusive use is expressly allowed by CMS and industry standard coding.*
>
> *The intent of the unique BIN/PCN provisions is to ensure: (1) that pharmacies can routinely identify situations in which they are billing a Part D claim; and (2) that payers secondary to Part D can properly coordinate benefits on Part D claims. These goals cannot reliably be met if Part D claims cannot be distinguished from other types of pharmacy claims through unique routing and beneficiary identifiers.*

Audit Off Record – An audit off record is created by the Transaction Facilitator when a previously accepted enrollment was retroactively terminated or cancelled by CMS such that no enrollment in the Part D plan exists during the coverage year. The audit off record allows Part D plans to report accumulators even though CMS systems do not reflect enrollment in the Part D plan for the beneficiary.

DTRR – Daily Transaction Reply Report is created by CMS each evening, Monday through Saturday, and is available for Part D plans the following business day. All Part D plans receive a DTRR for all contracts whether or not the plan has submitted transactions for processing by MARx. The file contains records that report the submitted transactions back to the Part D plans and the CMS response (see TRC).

MARx Batch Input Transaction Data File – A transaction file submitted to CMS by a Part D plan consisting of a header record followed by individual transaction records including enrollments, disenrollments, miscellaneous change detail records, such as 4Rx data changes, and enrollment/disenrollment cancellations. The transaction code (TC) identifies the type of transaction record. The response from CMS to the plan is reported in the Daily Transaction Reply Report (DTRR).

MA-PD - A Medicare Advantage (MA) plan that provides qualified prescription drug coverage.

P2P – Plan to Plan reconciliation is a financial settlement process between two Part D plans in which the plan of record compensates the plan submitting PDE data reporting claims paid on a beneficiary who belongs to the plan of record. The plan to plan reconciliation process is signaled by receipt of a PDE Error Number 708 or a 708/712 combination. See section "*Plan to Plan (P2P) Process*".

PBP – Plan Benefit Package is a set of benefits for a defined MA or PDP service area. .

PDP – Prescription drug plan, an MA-PD plan, a PACE Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage

PDE – The Prescription Drug Event record is used by Part D plans to report data to CMS that enable the agency to make four plan payments: the direct subsidy, low income subsidy, reinsurance subsidy, and risk sharing.

Proxy Add - A proxy add is the method for the Part D non-plan of record (or their processor) to notify the Transaction Facilitator that their non-plan of record should be included in FIR transaction sequences. A proxy add is used when there is no record of the beneficiary's enrollment in that plan in the CMS database.

Proxy Delete – A proxy delete is the method for the Part D non-plan of record (or their processor) to notify the Transaction Facilitator to remove the non-plan of record (audit off) from the Transaction Facilitator database because there are no accumulator data (paid claims) for the beneficiary.

Proxy Edit – A proxy edit is the method for the Part D non-plan of record (or their processor) to notify the Transaction Facilitator that the 4Rx information for their non-plan of record is not correct for a record that has already been proxy added or audited off. The proxy edit allows the non-plan of record to update the 4Rx information for the proxy added or audited off record.

Retroactive Termination – An enrollment termination effective for a month prior to the current month which was processed because:

- An enrollment was never legally valid;
- A valid request for disenrollment that was properly made, but not processed or acted upon;
- The beneficiary made a permanent move out of the plan service area;
- A plan committed a contract violation; or
- Other limited exceptional conditions established by CMS exist (e.g. fraudulent enrollment or misleading marketing practices).

TRC - Transaction Reply Code is reported on the Daily Transaction Reply Report (DTRR) and is CMS' response to the plan-submitted transaction and specifies whether the transaction was accepted, rejected or failed.

TTC - Transaction Type Code is a 2-digit number submitted on the MARx file specifying the type of transaction, such as code 61 for an enrollment transaction or code 72 for a 4Rx record update.

3. PART D NON-PLAN OF RECORD SCENARIOS

There are circumstances in which it is possible that a Part D plan that has enrolled a beneficiary does not actually become the beneficiary's Part D plan of record. The instances in which this occurs can be classified into categories as defined:

1. The Plan's Part D Enrollment Transaction for the Beneficiary was Never Sent to CMS or was Never Accepted by CMS; Claims Paid
2. The Plan's Part D Enrollment Transaction for the Beneficiary was Accepted by CMS

The scenarios below specifically addresses when multiple Part D plans have paid claims for the same beneficiary for the same period due to system's errors or retroactive disenrollment. While the years used for this document are 2012 and 2013, they are intended to reflect scenarios for the "current year" and "the subsequent year".

3.1 The Plan's Part D Enrollment Transaction for the Beneficiary was Never Sent to CMS or Never Accepted by CMS; Claims Paid

In this scenario, a Part D plan thinks the beneficiary has enrolled in their plan, however upon submission of the Part D enrollment file to CMS; CMS rejects the Part D enrollment. CMS will not have a record of the Part D plan in the CMS Part D enrollment system. This plan is the Part D non-plan of record.

If the non-plan of record has claims that contribute to the beneficiary's accumulators, the non-plan of record is responsible for reporting that information. Since the CMS Part D enrollment system will not have a record of the beneficiary's Part D enrollment in the non-plan of record, the Transaction Facilitator will not include the non-plan of record in any FIR transactions unless the non-plan of record notifies the Transaction Facilitator that they have accumulators for the beneficiary.

The method to notify the Transaction Facilitator that the non-plan of record should be included in FIR transaction sequences is called a **proxy add**. The non-plan of record should complete a proxy add. This can be done via a proxy add request by using the appropriate form. See http://medifacd.relayhealth.com/fir/non-plan-of-record. The proxy add time period filled in on the request should reflect the first day of the month that the first claim was paid and the last day of the month that the last claim was paid.

If the beneficiary is deceased, a proxy add should still be requested because the Part D plan does not know what may happen retrospectively.

Even if there is no record of a Part D plan of record for the period or a subsequent period, a proxy add should still be requested because a subsequent Part D plan may be added in the future. See http://medifacd.relayhealth.com/fir/non-plan-of-record.

Methods for identifying proxy add records. It is recommended that 1 and 2 be used.

1. The earliest method for identifying a beneficiary who may need a proxy add is by reviewing the Daily Transaction Reply Report (DTRR). If a beneficiary's Part D enrollment record has one of the Transaction Reply Code (TRC) and Transaction Type Code (TTC) listed below, the beneficiary's Part D enrollment record may be appropriate for a proxy add if you have paid claims for the beneficiary.

Source: CMS Plan Communications User Guide Appendices Version 7.0 (February 28, 2013)

Transaction Reply Code (TRC)	Short Definition	Definition	Transaction Type Code (TTC)	Description
36	Transaction Rejected,	A submitted enrollment or PBP change transaction	61	Enrollment

	Beneficiary is Deceased	(Transaction Type 61) or disenrollment cancellation transaction (Transaction Type 81) enrollment reinstatement was rejected because the beneficiary is deceased. The beneficiary DOD is reported in DTRR data record fields 18 and 24.		
106	Rejected, Another Trans Rcvd with Later App Date	An enrollment transaction (Transaction Type 61) was rejected because a transaction with a more recent application date or same date as another application date was received for the same effective date. The submitted enrollment has been overridden by an enrollment in another contract/PBP. When multiple transactions are received for the same beneficiary with the same effective date but with different contract/PBP #s, the application date is used to determine which enrollment to accept. If the application dates are different, the system will accept the election containing the most recent date.	61	Enrollment
108	Rejected, Election Limits Exceeded	A transaction for which an election type is required (Transaction Types 51, 61) was rejected because the transaction will exceed the beneficiary's election limits for the submitted election type. The valid Election Type values which have limits are: • A - Annual Election Period (AEP) 1 per calendar year • E - Initial Enrollment Period for Part D (IEP) 1 per lifetime • F - Initial Enrollment Period for Part D (IEP2) 1 per lifetime • I - Initial Coverage Election Period (ICEP) 1 per lifetime	61	Enrollment
114	DRUG Coverage Change Rejected; not AEP or OEPI	An enrollment change transaction (Transaction Type 61) was rejected because the beneficiary is not allowed to add or drop drug coverage using an O (OEP) or N (OEPNEW) election types. Using O or N, a beneficiary who is in a Plan that includes drug coverage may only move to another Plan with drug coverage. Likewise, if in a Plan without drug coverage, the beneficiary may not enroll in a Plan with drug coverage or a PDP. *Occasionally, if a beneficiary is moving from a Plan with drug coverage to a combination of stand-alone MA and PDP plans, the enrollment transaction in the MA-only plan may be processed prior to the enrollment transaction in the PDP plan. Since this appears to CMS as if the beneficiary is trying to drop drug coverage, the enrollment into the MA only Plan will be rejected with TRC 114. Once the enrollment in the PDP is processed, the enrollment in the MA-only may be resubmitted.*	61	Enrollment
127	Part D Enrollment Rejected; Employer Subsidy Status	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary has employer subsidy periods overlapping with the requested enrollment period. The requested effective date is reported in field 18 of the TRR record.	61	Enrollment
			72	Plan Change
128	Part D Enroll Reject; Emplyr Sbsdy set; No Prior Trn	An enrollment transaction (Transaction Type 61) was rejected because the beneficiary has employer subsidy periods overlapping with the requested enrollment period. Even through this transaction was submitted with the Employer Subsidy Override Flag set to Y, the override is not valid because there is no record that the enrollment was previously submitted and rejected with TRC 127 (Part D Enrollment Rejected; Employer Subsidy Status). CMS enforces this two-step process to ensure that the Plan discusses the potential consequences of the Part D enrollment (i.e. possible loss of employer health coverage) with the beneficiary before CMS accepts the employer subsidy override.	61	Enrollment
			72	Plan Change
157	Contract Not Authorized for Transaction Code	A transaction (Transaction Types 41, 51, 54, 61, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81) was rejected because the Plan is not authorized to submit that type of transaction.	41	Update to Opt-Out Flag (Submitted by CMS)
			61	Enrollment
			72	Plan Change

2. The second method for identifying a beneficiary who may need a proxy add is by reviewing the beneficiary records with PDE response Error Numbers.

a. *Assumptions:*
    i. *These are for paid claims since PDE record(s) are being submitted.*
    ii. *The normal date of service edit where the PDE record must be within 30 day of the effective date or the CMS process date will not apply because there is no record of eligibility in the CMS system.*
b. Any PDE record(s) submitted will receive Error Number 706.
c. Because the eligibility was never accepted, there would be no P2P report.
d. Because the eligibility was never accepted, the non-plan of record will not receive a FIR transaction unless a proxy is requested and there is at least one Part D plan of record in the system.

This is an example where a proxy add is needed:
Once the Part D plan terminates the beneficiary, usually the processor's system for non-plans of record will reflect a Part D enrollment record with the same effective and termination dates. Processors need to ensure they can handle a FIR transaction for a proxy add when the beneficiary's effective and termination dates are the same. If the beneficiary has accumulated balances, a FIR transaction needs to be generated and responded to, regardless of the effective and termination dates. Note: If a FIR transaction has not been generated or has not been successfully responded to, it is incumbent upon the non-plan of record to ensure the transfer of accumulated balances.

Example 1: Original (non-adjusted) PDE(s) Filed and Accepted with a Date of Service **within 30 Days** of the Part D enrollment Effective Date or Received Date (whichever is greater) for the Current Plan of Record

- Newly enrolled beneficiary that Plan A enrolled
- Plan A's Part D enrollment **was never accepted** by CMS
- Plan B's Part D enrollment was accepted on 12/28/2012 and effective 01/01/2013
    - Any PDE submitted by Plan A will return Error Number 706.
    - In this situation, **no FIR transaction will be generated** as a result of the non-plan of record as only one Part D plan exists in the CMS database. If accumulated balances exist under Plan A, Plan A will need to follow the steps outlined above for a proxy add for that beneficiary.

3.2 The Plan's Part D Enrollment Transaction for the Beneficiary was Accepted by CMS

In this scenario, a plan's Part D enrollment was processed and accepted by CMS; however, at some point later another Part D plan retroactively becomes the plan of record, thus retroactively terminating the prior plan's Part D enrollment for some or all the prior months of coverage. There is a period of time when the prior plan, that was retroactively terminated, paid as if it were the plan of record.

In this case, the Transaction Facilitator is able to identify the retroactive Part D enrollment for the new plan, the termination of the prior Part D plan, and will create an audit off record. The terminated Part D plan becomes a non-plan of record that will continue to be included in FIR transaction sequences. The terminated Part D plan continues to be included in the FIR transaction sequences to ensure that any accumulators are transferred to the plan of record.

If the retroactively terminated Part D plan does not have any accumulators for the beneficiary, they can request that the audit off record be deleted (proxy delete) and the plan no longer be included in FIR transaction sequences. This can be done via a proxy delete request by using the appropriate form. See http://medifacd.relayhealth.com/fir/non-plan-of-record.

Note: If a proxy delete request form is submitted for a beneficiary, but the submitting Part D plan's last FIR transaction response contained accumulators **for months during which the plan was not the plan of record**, the audit off record will not be deleted. For the audit off record to be deleted, the last FIR transaction response provided by the Part D plan requesting the deletion must not contain any accumulators.

Retroactive Termination with No Active Coverage in the Plan Year – The Enrollment transaction was accepted by CMS; however the entire enrollment period for the Part D plan was retroactively terminated, resulting in no coverage for that Part D plan in the plan year. There are two scenarios; each will result in an audit off record:

- The coverage is retroactively terminated to a prior plan year, resulting in no coverage in the current year.
    - Calendar year plan example:
        - Originally accepted coverage effective date 11/01/2011 and continues through 2012.
        - Retroactive termination received 02/01/2012 resulting in no coverage for 2012 and terminating the coverage as of 12/31/2011.
- The coverage is retroactively terminated to within the current plan year, resulting in no coverage in the current year.
    - Non-calendar year plan example:
        - Originally accepted coverage effective date 07/01/2012.
        - Retroactive termination received 07/15/2012 resulting in no coverage for 2012 with a termination as of 06/30/2012.

Retroactive Termination with Some Active Coverage Remaining in the Plan Year – The Enrollment transaction was accepted by CMS, however only a portion of the enrollment for the Part D plan was retroactively terminated; so a period of coverage remains in the CMS system for the plan. In this example, no audit off record was created because there is still a period of eligibility for the plan in CMS' system. Part D plans should report accumulators for all months in which they paid claims regardless of the eligibility period in CMS' system.

- Example
    - Originally accepted coverage effective date 01/01/2012
    - Retroactive termination received 07/15/2012 terminating the coverage to 03/31/2012

If the plan has accumulators for any months between 04/01/2012 – 7/15/2012, the Part D plan should ensure that their processor will appropriately respond to any FIR transaction with accumulators for all months in which claims were paid.

3.2.1 Enrollment Transaction was Accepted by CMS; Retroactive Termination with Some Active Coverage Remaining in the Plan Year

3.2.1.1 Original (non-adjusted) PDE(s) Accepted with a Date of Service within 30 Days of the Part D Enrollment Effective Date or Received Date (whichever is greater) for the Current Plan of Record

- January through March of 2012 Plan A thinks they have the beneficiary and pays claims.
- 02/27/2012 Plan B submits Part D enrollment that is retroactively effective back to 02/01/2012 and CMS processes on 02/27/2012. **Note:** Plan A is plan of record for the month of January.
    - January PDEs will process with no errors because Plan A is plan of record.
    - Any PDE submitted by Plan A with a Date of Service that is during the non-plan of record period and is equal to or less than 30 days from 02/27/2012 will receive Error Number 708.
    - On 03/31/2012, Plan A sends a PDE adjustment for a claim with a Date of Service equal to or less than 30 days from 02/27/2012, the adjustment will continue to receive the Error Number 708 (don't use the adjusted PDE - Plan A should have already identified the beneficiary based on the PDE above.)
    - In this situation, a P2P receivable report would be sent to Plan A and a P2P payable report would be sent to Plan B.
      A FIR will be generated around 02/27/2012 due to the new plan being added.

3.2.1.2 Original (non-adjusted) PDE(s) Filed and Accepted with a Date of Service <u>after</u> 30 Days of the Part D enrollment Effective

DATE OR RECEIVED DATE (WHICHEVER IS GREATER) FOR THE CURRENT PLAN OF RECORD

- January through March of 2012 Plan A thinks they have the beneficiary and pays claims.
- 02/27/2012 Plan B submits Part D enrollment that is retroactively effective back to 02/01/2012 and CMS processes on 02/27/2012. **Note:** Plan A is plan of record for the month of January.
    - January PDEs will process with no errors because Plan A is plan of record.
- Plan A submits first/original PDE submission for a claim with a Date of Service of 04/01/2012. This claim is outside the 30-day window of the process date.
    - The PDE Date of Service is more than 30 days after 02/27/2012 (Received Date is used because it is more than 30 days after the effective date) and will receive Error Number 706.
    - The PDE will not show up on P2P Reports (because it is more than 30 days from the effective date).
    - A FIR transaction will be generated around 02/27/2012 due to the new plan being added.
    - Note that the period of eligibility in Plan A that was retroactively terminated is for the month of February in this instance only, however Plan A paid claims in the month of April in this example (perhaps due to a delayed system update).
    - Plan A must respond to the FIR transaction and report any accumulators for all claims paid.
    - There will be no P2P report generated because the PDE was never accepted.
        - Plan A may seek reimbursement from Plan B; however, it will be outside the P2P process. (See section "*Exception to the Process*")

3.2.2 ENROLLMENT TRANSACTION WAS ACCEPTED BY CMS; RETROACTIVE TERMINATION, AS A RESULT THERE IS NO COVERAGE IN THE PLAN YEAR

- January and February of 2012 Plan A thinks they have the beneficiary and pays claims.
- 01/27/2012 Plan B submits Part D enrollment that is retroactively effective back to 01/01/2012 and CMS processes on 01/27/2012.
    - Any PDE submitted by Plan A will receive Error Number 706.
    - In this situation, a P2P will not occur.
    - A FIR transaction will be triggered as a result of the new plan being added
        - In this situation if Plan A, rejects the FIR transaction, the retroactively terminated record will be reported on the Daily Cumulative FIR Reject Report under the Non-Plan of Record column with a value equal to "A" (Audit off).
        - See http://medifacd.relayhealth.com/fir/reports for more information on the Daily Cumulative FIR Reject Report.
    - Plan A should not request a proxy delete. The beneficiary has accumulators and the plan must appropriately respond to the FIR transaction even though the effective date has been retroactively terminated.
    - There will be no P2P report generated because the PDE was never accepted.
        - Plan A may seek reimbursement from Plan B; however, it will be outside the P2P process. (See section "*Exception to the Process*")

3.2.2.1 ENROLLMENT TRANSACTION ACCEPTED BY CMS AND THEN TERMINATED (NON-RETROACTIVELY); HOWEVER, THE PLAN CONTINUES TO PAY CLAIMS IN THE SAME PLAN YEAR

(This scenario usually occurs due to file transfer and load timing)

- January of 2012 Plan A has accepted enrollment for January and thinks they continue to have the beneficiary in February. They paid claims the first five days of February until the updated plan eligibility file containing the disenrollment gets to the PBM.
- 01/31/2012 Plan B submits Part D enrollment that is effective 02/01 and CMS processes on 01/31/2012.
    - January PDEs will process with no errors because Plan A is plan of record.

- Any PDE submitted by Plan A for a date of service in February would be equal to or less than 30 days from 01/31/2012 and will receive Error Number 708.
- On 03/31/2012, Plan A sends an adjustment for the same claim identified above, the adjustment will continue to receive Error Numbers 708
- In this situation, a P2P receivable report would be sent to Plan A and a P2P payable report would be sent to Plan B.
- A FIR series will be generated around 01/31/2012 because of the plan change.
- The beneficiary has accumulators and the plan must appropriately respond to the FIR series and report accumulated balances for January and February even though the beneficiary was not active in February.

3.2.2.2 Enrollment Transaction Accepted by CMS and then Terminated (non-retroactively); However, the Plan Continues to Pay Claims across Plan Years

(This scenario usually occurs due to file transfer and load timing at the end of a plan year)

- Beneficiary is enrolled with Plan A in December 2011 and the plan thinks they will continue to have the beneficiary in January 2012 and pays claims with dates of service in January 2012.
- On 12/31/2011 the beneficiary is auto enrolled in Plan B effective 01/01/2012 and CMS processes on 12/31/2011.
  - January PDEs for Plan A will receive Error Number 706 because no record of coverage exists for Plan A for the new plan year.
  - In this situation, **no FIR transactions will be generated** as a result of the non-plan of record as only one plan exists in the CMS database. If accumulated balances exist under Plan A; Plan A will need to follow the steps outlined above for a proxy add for that beneficiary.
  - In this situation, no P2P report would be generated because no record of coverage exists in CMS' system for Plan A for the new plan year.

4. CHANGING 4RX INFORMATION FOR AN AUDIT OFF RECORD (PROXY EDIT)

If the 4Rx submitted on the enrollment transaction by a plan for a beneficiary was incorrect and the enrollment transaction was accepted by CMS, but subsequently retroactively terminated, the termination will eliminate the 4Rx and the associated enrollment period from the CMS system. However, the incorrect 4Rx data will have been reported by CMS to the TrOOP Facilitator and exist in their database.

The retroactive termination by CMS results in the Transaction Facilitator creating an audit off record. But, this audit off record will contain the erroneous 4Rx resulting in FIR transaction rejections by the plan's processor.

Because the erroneous 4Rx data no longer exist in the CMS system, the correction cannot be made through CMS. Instead, in order to process the FIR transaction, the plan must submit a proxy edit to the Transaction Facilitator to correct the 4Rx data on the beneficiary's audit off record.

5. PROCESSOR APPROACH TO RETROACTIVE TERMINATION WITH ACCUMULATORS

This section discusses how the Part D Plan insures the processor can respond to Financial Information Reporting transactions for beneficiaries whose Medicare Part D enrollment was originally accepted by CMS and has been retroactively terminated and accumulators exist.

There are two approaches for Part D plans (or their processors) to handle retroactive terminations **where the entire coverage period for a plan year is eliminated** for a beneficiary, but accumulator data exist. These approaches allow Financial Information Reporting, Information Reporting (N) transaction processing, and billing claim reversals, but not the processing of new claims. The processor's system may reflect either:

- Effective and termination dates that are the same, or
- A termination date that is one day prior to the effective date.

In either instance, processors should support Financial Information Reporting, Information Reporting (N) transaction processing, and billing claim reversals.

6. EXCEPTION TO THE PROCESS

If the beneficiary is retroactively terminated back to a prior plan year (no coverage exists for the current plan year), any claims paid by the Part D non-plan of record will be rejected on a PDE with Error Number 706 as of the effective date of the retro-termination. In addition, because the claims will reject on the PDE, they will not be included in P2P reconciliation.

For the exceptions below, a P2P report is not generated. CMS does not anticipate any changes to the P2P process. Part D plans are responsible for coordination of benefits with other Part D plans as other payers. As such, NCPDP's WG1 Financial Information Reporting Task Group intends to develop a standardized format for the manual transfer of data. Until one is developed, a Part D plan of record may receive a request in a non-standardized format from a non-plan of record. Below are some examples of scenarios that may warrant a manual data exchange outside the P2P process.

Scenario One: Enrollment is retroactively terminated to a prior year; FIR transactions are automatically generated however there is no method for the plan to recoup payment from the current plan of record.

- A beneficiary's enrollment has been accepted by CMS effective 01/01/2011 to 03/31/2013 (it could, however also be open ended)
- On 01/15/2013, the beneficiary is retroactively terminated back to 10/31/2012.
- Any claims paid in 2013 will not be included in P2P reconciliation because the entire 2013 record has been eliminated from the CMS system (audited off) causing the PDE to reject. Note: There is still active coverage in the CMS system for 2012.
- The retroactive termination across the plan years results in an audit off record being created and a 2013 FIR series will be triggered *provided there is a plan of record for the plan year of 2013.*
- Depending on when the plan submits the PDE it may or may not get accepted.
    - If submitted prior to 01/15/2013 for 2013 claims, the initial PDE would be accepted, but if a subsequent adjustment is submitted on or after 01/15/2013 it will receive Error Number 706.
    - If the first PDE is submitted on or after 01/15/2013 it will receive Error Number 706.
    - A FIR transaction will be triggered.
- Plan A may seek reimbursement from Plan B (current plan of record); however, it will be outside the P2P process.

Scenario Two: Enrollment is retroactively terminated for the current plan year resulting in no coverage for that plan and there is no method for the plan to recoup payment from the current plan of record.

- A beneficiary's enrollment has been accepted by CMS effective 01/01/2013.
- On 01/15/2013, the beneficiary is retroactively terminated back to 01/01/2013; the result is no coverage in CMS system at all for the plan year 2013.
- The retroactive termination within the plan year results in an audit off record being created; a FIR transaction will be triggered provided there is a plan of record during the plan year.
- Any claims paid in 2013 will not appear on a P2P report because the entire 2013 record has been eliminated from the CMS system, causing the PDE to reject.
- Depending on when the plan submits the PDE, it may or may not get accepted.
    - If submitted prior to 01/15/2013 for 2013 claims, the initial PDE would be accepted, but if a subsequent adjustment is submitted 01/15/2013 or later it will receive Error Number 706.
    - If the first PDE is submitted on or after 01/15/2013, it will receive Error Number 706.
    - A FIR transaction will be triggered.
- Plan A may seek reimbursement from Plan B; however, it will be outside the P2P process.

Scenario Three: Enrollment is received on 12/20/2012 for a 01/01/2013 effective date. Enrollment is terminated on 12/31/2012, which deletes the record from the CMS system. The plan pays claims in January prior to terminating the enrollment in the processor's system.

- Because the termination occurred prior to the plan year, no audit off record is created by the Transaction Facilitator and no FIR transaction will be triggered.
- Any claims paid in 2013 will not be included in P2P reconciliation because the entire 2013 enrollment record has been eliminated, causing any PDEs to reject.
- Any PDEs submitted will receive Error Number 706.
- The plan needs to request a proxy add to ensure that the accumulators are available to the plan of record for 2013.
- Plan A may seek reimbursement from Plan B; however, it will be outside the P2P process.

Scenario Four: Enrollment received prior to 01/01/2013 with an effective date of 01/01/2013 and Transaction Facilitator receives a file on 01/01/2013 from CMS that deletes that record, the Transaction Facilitator will not generate a FIR transaction, even if the new plan of record is effective 01/01. This only happens on 01/01.

- A termination as of the effective date will not result in an audit off record being created by the Transaction Facilitator and no FIR transaction will be triggered.
- Any claims paid in 2013 will not appear on the P2P report because the entire 2013 record has been eliminated causing any PDEs to reject.
- Any PDEs submitted will receive Error Number 706.
- The plan needs to request a proxy add to ensure that the accumulators are available to the plan of record for 2013.
- Plan A may seek reimbursement from Plan B; however, it will be outside the P2P process.

7. APPENDIX A. HISTORY OF CHANGES